

The newsletter of
Ireland's focal point
to the EMCDDA

drugnet IRELAND

Issue 64 | Winter 2018

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New estimates of problem opiate use in Ireland

In December, 2017 the National Advisory Committee on Drugs and Alcohol (NACDA) published the findings of the third study estimating the prevalence of problematic opiate use in Ireland.¹ An opiate is a drug containing opium or any of its derivatives that acts as a sedative and narcotic. Examples include heroin, methadone, morphine, codeine, hydrocodone, fentanyl and tramadol. Heroin is synthesised from morphine, a naturally occurring substance extracted from the seed pod of the Asian opium poppy plant,² and is available in three forms: a white power, a brown powder or a black sticky substance known as 'black tar heroin'.

Capture-recapture studies

National 3-source capture-recapture (CRC) studies to provide statistically valid estimates of the prevalence of opiate drug use in the Irish population were commissioned by the National Advisory Committee on Drugs and Alcohol (NACDA) and undertaken in 2001³ and 2006.⁴ The three data sources used were the Central Treatment List (of clients on methadone), the Hospital In-Patient Enquiry scheme and the Garda PULSE data.



Kieran Doherty, CEO of the the Alcohol Forum, Paula Leonard, National Lead, Community Action on Alcohol, and Senator Frances Black at the fourth national conference of the Alcohol Forum in Letterkenny. (See report on the conference on page 21)

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The policy, research and other documents covered in this issue of *Drugnet Ireland* have all been retrieved by the HRB National Drugs Library and may be accessed on its website www.drugsandalcohol.ie

In brief

Supporting community-based organisations' use of evidence is an effective way to link research to action in health programmes. One approach to this work is to develop a strategy of community-based knowledge transfer and exchange to facilitate the use of research evidence in service planning and delivery.

Researchers working on this topic have identified a number of activities that are key to the success of these strategies: fostering a culture favourable to the use of research evidence and which recognises its importance in decision-making; providing evidence that is directly relevant to the work of community-based organisations; supporting activities that link research evidence to action; and, evaluating these efforts.

Community-based organisations have a key role in implementing the actions in *Reducing harm, supporting recovery*. In fulfilling this role, they will need support in finding, selecting and using evidence in decision-making and implementing the findings of research in service delivery and advocacy work. One obstacle to increasing the effective use of evidence in non-governmental, voluntary and community-based services has been the lack of material tailored to the needs of these stakeholders and providing clearly written, accessible and persuasive guidance on identifying and implementing research findings. There has been substantial improvement in this area in recent years. In the United Kingdom, the third sector supports a number of organisations who specialise in guiding organisations through the steps of evidence-based decision making, and the volume of literature supporting this work has grown substantially over the past few years.

In this issue, we highlight a new resource published by the EMCDDA which provides services with an excellent introduction for anyone attempting to understand the role that research evidence can play in making their work more effective, sustainable and impactful. The resource, *Health and social responses to drug problems: a European guide* aims to encourage a way of thinking around how to respond to particular problems in particular settings. It provides a brief overview of current knowledge on a number of significant drug-related issues and attempts to answer what we know already about the issue, what works, and what can be done to respond to it. The guide is supported by an online platform on the EMCDDA's best practice portal. It is a companion document to the EMCDDA's report on the drugs market. The two documents complement each other and represent significant progress in the work of building an informed, empowered and confident community response to problem drug use.

New estimates of problem opiate use continued

A third study using the CRC method was commissioned by the NACDA in 2014.¹ In this research, four data sources were utilised: (1) drug treatment clinic data; (2) information from general practice; (3) prison records; and (4) statistics provided by the Irish Probation Service. This article highlights some of the study findings.

Prevalence of opiate use

Tables 1 and 2 show prevalence estimates of opiate use in the Republic of Ireland. For the current study, data from the four sources indicated that the national prevalence estimate of opiate users in 2014 was between 18,720 and 21,454. The point estimate was 18,988, giving a rate of 6.18 per thousand population aged 15–64 years (95% CI: 6.09–6.98).

Seventy-one per cent of the estimated number of opiate users lived in Dublin. The estimates for Dublin were 13,458 (95% CI: 12,564–14,220), suggesting a population rate of 15.15 per thousand population. The corresponding figures for 2006 were 14,909 (95% CI: 13,737–16,450) with a population rate of 17.6 per thousand population. The prevalence for the rest of Ireland (excluding Dublin) was determined to be 5530 (95% CI: 5406–8023). This also represents a slight decrease when compared to estimates from 2006 (5586, 95% CI: 4399–7126). Sixty-nine per cent of opiate users in 2014 were male.

In terms of regional differences, County Sligo had the lowest prevalence of opiate use with a rate of 0.37 per thousand population (95% CI: 0.21–1.73). Other counties with prevalence rates lower than 1.0 per thousand were Donegal, Leitrim, Mayo and Monaghan.

Table 1: Summary of prevalence estimates of opiate use in Ireland, 2014

Area	Estimate	Lower bound	Upper bound	Rate/1000 population
Dublin	13,458	12,564	14,220	15.15
Rest of Ireland	5530	5406	8023	2.53
Age group				
15–24 years	1092	1076	1234	1.88
25–34 years	6672	6578	7539	8.84
35–64 years	11,224	11,065	12,681	6.46
Gender				
Female	5966	5882	6741	3.86
Male	13,022	12,838	14,713	8.52

Source: NACDA, 2017

Table 2: Estimated prevalence of opiate use in Ireland for 2001, 2006 and 2014

Area	2001				2006				2014			
	Estimate	Lower bound	Upper bound	Rate/1000 population	Estimate	Lower bound	Upper bound	Rate/1000 population	Estimate	Lower bound	Upper bound	Rate/1000 population
Dublin	12,456	11,519	13,711	15.9	14,909	13,737	16,450	17.6	13,458	12,564	14,220	15.15
Rest of Ireland	2225	1934	2625	1.2	5886	4399	7126	2.9	5530	5406	8023	2.53
State total	14,681	13,404	15,819	5.6	20,790	18,136	23,576	7.2	18,988	18,720	21,454	6.18

Source: NACDA, 2017



Dr Gordon Hay of the Public Health Institute, Liverpool John Moores University, and author of the problem opiate use study

With regard to city differences, after Dublin City, Limerick City had the highest rate of use at 8.82 per thousand population (95% CI: 7.11–13.16) followed by Waterford City (6.72, 95% CI: 5.24–15.12) and Cork City (5.67, 95% CI: 4.91–6.71). Galway City had the lowest prevalence of opiate use at 1.93 per thousand (95% CI: 1.55–2.73).

Trends

The following trends were observed in the study results:

- There has been a slight decrease in opiate use both inside and outside of Dublin when compared to 2006.
- The rate of opiate use among males and females aged 15–24 years has continued to decline.
- More than one-half (60%) of the State's opiate users are in the 35–64 age group, compared to less than one-third in 2006, suggesting a definite ageing cohort effect.

Conclusions

Findings from the current 4-source CRC study suggest that opiate use in Ireland has stabilised. Nevertheless, the study authors highlight that there is limited validity in making direct comparisons between studies and that none of the slight decreases observed were statistically significant.

Seán Millar

- 1 Hay G, Jaddoa A, Oyston J, Webster J, Van Hout MC, Rael dos Santos A (2017) *Estimating the prevalence of problematic opiate use in Ireland using indirect statistical methods*. Dublin: National Advisory Committee on Drugs and Alcohol. <http://www.drugsandalcohol.ie/27233/>
- 2 National Institute on Drug Abuse (2017) DrugFacts: Heroin. <https://www.drugabuse.gov/publications/drugfacts/heroin>
- 3 Kelly A, Carvalho M and Teljeur C (2003) *Prevalence of opiate use in Ireland 2000–2001: a 3-source capture recapture study*. Dublin: Stationery Office. <http://www.drugsandalcohol.ie/5942/>
- 4 Kelly A, Teljeur C and Carvalho M (2009) *Prevalence of opiate use in Ireland 2006: a 3-source capture recapture study*. Dublin: Stationery Office. <http://www.drugsandalcohol.ie/12695/>

PREVALENCE AND CURRENT SITUATION

Drug-related deaths and deaths among drug users 2004–2015

The HRB published the latest figures from the National Drug-Related Deaths Index (NDRDI) in December 2017.¹ The new bulletin presents an overview of trends due to poisoning (overdose) by alcohol and/or other drugs, and deaths among drug users (non-poisoning) in the period 2004–2015 (Figure 1).

In the 12-year period 2004–2015, there were a total of 7,422 drug-related deaths (Table 1):

- 4,222 (57%) were due to poisoning.
- 3,200 (43%) were due to non-poisoning.

In 2015, there were 695 deaths (poisoning and non-poisoning combined), marginally lower than the number reported in 2014 (n=719):

- Median age for all deaths in 2015 was 41 years and 72% (n=503) of all deaths were male.
- There were approximately 20,000 of potential life years lost because of drug-related deaths in 2015.

Drug-related deaths in 2015 among injectors:

- 8% of all deaths were among injectors.
- 52% of injectors died in Dublin city.

Poisoning deaths in 2015

The annual number of poisoning deaths decreased by 4%, from 364 in 2014 to 348 in 2015. Almost two-thirds of poisoning deaths involved polydrugs, with an average of four different drugs involved. Benzodiazepines were the most common drug group implicated in polydrug deaths.

Prescription drugs were implicated in two out of three poisoning deaths:

- Diazepam (a benzodiazepine) was the most common single prescription drug implicated in almost one-third (101, 29%) of all poisonings.
- Methadone was implicated in one-quarter of poisonings (86, 25%).
- Pregabalin-related deaths (an antiepileptic drug also prescribed for chronic pain and some anxiety conditions) increased by 69%, from 26 deaths in 2014 to 44 in 2015.

The number of deaths where the illicit drug cocaine was implicated increased by 110% since 2010:

- Cocaine-related deaths have been increasing since 2010, with 44 deaths reported in 2015 compared to 21 in 2010.

Alcohol was implicated in 107 deaths (31% of all poisonings):

- Alcohol alone was responsible for 14% (n=47) of all poisoning deaths in 2015.

Non-poisoning deaths in 2015

The number of non-poisoning deaths decreased by 2%, from 355 in 2014 to 347 in 2015. The main causes of non-poisoning deaths were hanging (83, 24%) and cardiac events (55, 16%):

- Of those who died as a result of hanging, over one-half (59%) had a history of mental health problems.

Trends from 2004 to 2015

In the 12-year period 2004–2015, a total of 7,422 poisoning deaths and deaths among drug users met the criteria for inclusion in the NDRDI database. The number of deaths increased by 61% during this period, from 431 in 2004 to 695 in 2015.

Deaths among injectors

People who were injecting at the time of the incident that led to their death represented 8% of all drug-related deaths in 2015 (Table 2). Of these deaths:

- 93% were male.
- 89% were poisoning deaths.
- 52% died in Dublin city.
- 94% of the poisoning deaths involved opiates.

Of those injectors who died in 2015 of a poisoning death which involved opiates:

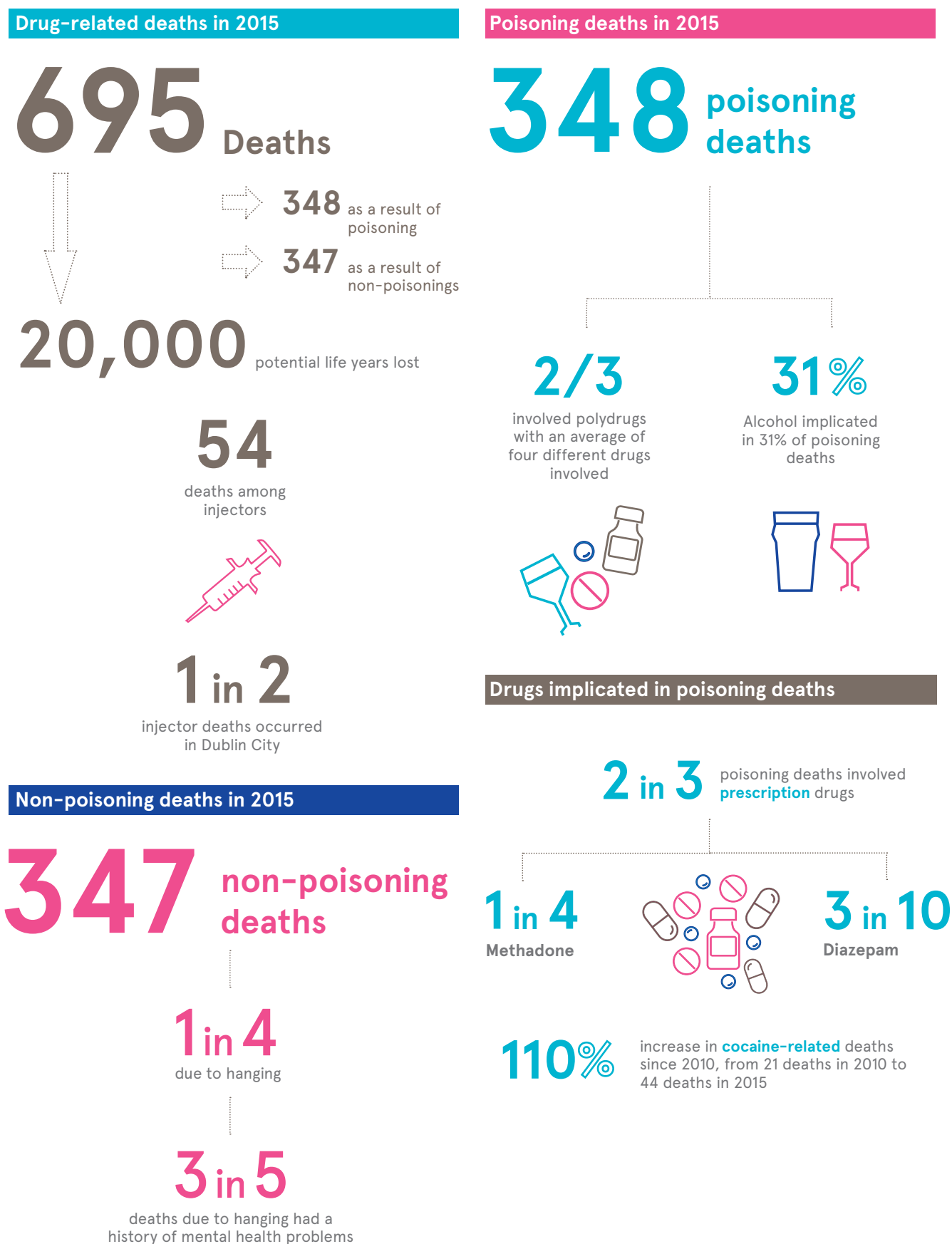
- 40% were not alone at the time of the incident that led to their death.
- 20% injected in a public place.
- 27% involved a single opiate type drug.

Ena Lynn and Suzi Lyons

1 Health Research Board (2017) *National Drug-Related Deaths Index 2004 to 2015 data*. Dublin: Health Research Board. <http://www.drugsandalcohol.ie/28086/>

Drug-related deaths 2004–2015 continued

Figure 1: National Drug-Related Deaths Index, 2015 data



Drug-related deaths 2004–2015 continued

Table 1: Number of deaths, by year, NDRDI 2004 to 2015 (n=7422)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
All deaths (total)	431	503	554	620	628	656	607	645	660	704	719	695
Poisonings (4222)	266	301	326	387	386	372	339	377	356	400	364	348
Poisonings male	175	199	228	270	274	254	251	274	264	273	263	230
Poisonings female	91	102	98	117	112	118	88	103	92	127	101	118
Median age	40	39	36	36	38	38	40	39	40	41	39	41
Non-poisonings (3200)	165	202	228	233	242	284	268	268	304	304	355	347
Non-poisonings male	153	176	192	177	196	212	207	218	233	236	278	273
Non-poisonings female	12	26	36	56	46	72	61	50	71	68	77	74
Median age trauma	27	27	27	28	28	30	32	30	31	34	33	34
Median age medical	38	38	43	42	42	40	44	45	46	47	47	49

Table 2: Individual deaths among injectors, NDRDI 2004 to 2015 (n=628)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
All NDRDI deaths	431	503	554	620	628	656	607	645	660	704	719	695
Injectors at time of death (% of all deaths)	34 (7.9)	49 (9.7)	61 (11.0)	55 (8.9)	67 (10.7)	69 (10.5)	50 (8.2)	47 (7.3)	37 (5.6)	49 (7.0)	56 (7.8)	54 (7.8)
All injector deaths	34	49	61	55	67	69	50	47	37	49	56	54
Male	31	43	55	40	47	58	45	41	32	42	49	50
Female	~	6	6	15	20	11	5	6	5	7	7	~
Place of incident*												
Dublin City	*	*	*	*	*	*	*	*	21	28	29	28
Outside of Dublin City	*	*	*	*	*	*	*	*	16	21	27	26
Type of death												
Poisoning	31	42	56	52	54	56	44	42	35	47	52	48
Non-poisoning	~	7	5	~	13	13	6	5	~	~	~	6
All poisoning deaths	266	301	326	387	386	372	339	377	356	400	364	348
Poisoning deaths involving injectors (% of all poisoning deaths)	31 (11.7)	42 (14.9)	56 (17.2)	52 (13.4)	54 (14.0)	56 (15.1)	44 (13.0)	42 (11.1)	35 (9.8)	47 (11.8)	52 (14.3)	48 (13.8)
Poisoning deaths among injectors involving opiates of whom:	30	39	50	48	51	54	41	39	32	46	50	45
Deceased was not alone	9	23	24	24	29	32	20	17	17	17	23	18
Deceased was in a public place	8	10	17	13	7	12	7	5	5	7	18	9
Death was caused by a single opiate drug	19	12	24	15	13	22	20	12	6	15	14	12

~ Less than five deaths.

* NDRDI.

Drugs-related deaths rapid evidence review: keeping people safe

In the context of rising drug-related deaths, and an increasingly vulnerable ageing cohort of people with drug problems,¹ what does the evidence tell us about keeping people safe?

This was the question posed for a rapid evidence review by NHS Scotland² to inform a conference held by the Scottish Government along with the Partnership for Action on Drugs in Scotland (PADS) in July 2017 entitled 'Drug Policy through a Health Lens'.

Methodology

The report provided a combination of findings from the evidence based on the critical appraisal of systematic reviews and grey literature reports.

Findings

The evidence was divided into three categories listed as follows:

- Seek – engagement and access to services
- Keep – characteristics of treatment and support
- Treat – benefits of treatment

Drugs-related deaths rapid review

continued

1. Seek – engagement and access to services

Many complex barriers exist preventing older people seeking and maintaining support for a drug problem, including financial restrictions, negative perceptions of services, feelings of shame and stigma, loneliness and isolation, and having multiple health issues due to their long-term drug use. The vulnerable nature of this group means that they are not accessing services and, when they do, they are frequently dropping out. In order to support individuals to access services and treatments, these psychological and social barriers need to be addressed. In response to this, the evidence from the review found that using a more holistic approach tailored to the individual improves effectiveness of interventions, increases motivation, and prevents dropout.

The review found that blood-borne viruses and risk behaviours are reduced when individuals engage with treatment and harm reduction services.^{3,4} In addition, the likelihood of recovery from overdose is increased by the use and awareness of take-home naloxone programmes. Providing training and education to users and their families and peers on recognising signs of overdose and how to intervene enables them to intervene and potentially save a life.^{5,6} Before and upon release from prison is a critical time for providing support to drug users, and the evidence demonstrates that drug-related deaths can be prevented if prison staff are sufficiently trained in harm reduction practices and risks of overdose. Pre-release education on overdose risks and prevention, liaising with addiction services upon release, and training for prisoners with a history of drug abuse and their families on overdose awareness and naloxone use were indicators of good practice.

2. Keep – characteristics of treatment and support

The first four weeks of treatment and the first four weeks upon leaving treatment have been identified as periods of high-risk for drug-related deaths and, as such, are critical intervention points to prevent such deaths.⁷ Having clear re-engagement processes and procedures for those moving through treatment and for those who have disengaged are an important factor in engagement.

The review data indicate that medications should not be viewed as a 'one size fits all' and each individual should be considered as an individual. Regularly involving users and their families in drug prescribing and treatment options is important. Updating and reviewing care plans and adjusting drug dosage depending on effectiveness have been highlighted as good practice indicators along with strategies and processes to engage and maintain continuity of care.⁸

For those with opioid dependence, the most positive outcomes for remaining in treatment and for benefits from treatment (e.g. reduced drug use) were seen when a person-centred, holistic approach, including psychosocial interventions,⁹ is delivered in conjunction with medication-assisted treatment.¹⁰ There is limited but growing evidence that contingency management¹¹ is effective in increasing treatment retention and promoting abstinence from drugs.

Awareness of and subsequent staff training for age-specific issues¹² was identified as having a positive impact on

treatment outcomes for older drug users. A distinction has been made between early onset and late onset of drug problem use with important implications for treatment and recovery approaches. Age-appropriate support for this group is important, including involvement of multidisciplinary health professionals (due to complex mental and physical ill-health), the importance of understanding polydrug use to reduce drug-related harms, and ensuring that treatment plans are pragmatic and tailored to their multiple issues.

There is limited evidence available for identifying gender, ethnicity or social class differences in effectiveness of outcomes.

3. Treat – benefits of treatment

The mortality risk of people with opioid dependence is reduced when in substitution treatment.⁷ Finding the balance between optimal dosage and remaining in treatment tends to have the most positive impact on outcomes. Medication-focused approaches were found to have better retention rates (compared to placebo or no medication), but medications should be modified according to the individual's requirements with consideration for the needs of vulnerable older users. Evidence suggests that where previous treatments have been unsuccessful, older entrenched heroin users may find that heroin-assisted approaches may be more appropriate.

Anne Doyle

- 1 For the purpose of the review, older people with a drug problem are categorised as those aged over 35 years who experience health and social harms related to their own drug use.
- 2 Dickie E, Arnot J and Reid G (2017) *Drugs-related deaths rapid evidence review: keeping people safe*. Edinburgh: NHS Health Scotland. Available online at <http://www.healthscotland.scot/media/1609/drugs-related-deaths-rapid-evidence-review.pdf>
- 3 Harm reduction services include needle and syringe programmes, supervised drug consumption clinics, and methadone maintenance.
- 4 Fernandes RM, Cary M, Duarte G, et al. (2017) Effectiveness of needle and syringe programmes in people who inject drugs – an overview of systematic reviews. *BMC Public Health*, 17(1): 309.
- 5 Giglio RE, Li G and DiMaggio CJ (2015) Effectiveness of bystander naloxone administration and overdose education programs: a meta-analysis. *Inj Epidemiol*, 2(1): 10.
- 6 McDonald R and Strang J (2016) Are take-home naloxone programmes effective? Systematic review utilizing application of the Bradford Hill criteria. *Addiction*, 111(7): 1177–87.
- 7 Sordo L, Barrio G, Bravo MJ, et al. (2017) Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ*, 357: J1550.
- 8 Timko C, Schultz NR, Cucciare MA, et al. (2016) Retention in medication-assisted treatment for opiate dependence: a systematic review. *J Addict Dis*, 35(1): 22–35.
- 9 Psychosocial interventions include contingency management, cognitive behavioural therapy (CBT), motivational interviewing, counselling, mutual aid, and telephone/web-based support.
- 10 Dugosh K, Abraham A, Seymour B, et al. (2016) A systematic review on the use of psychosocial interventions in conjunction with medications for the treatment of opioid addiction. *J Addict Med*, 10(2): 91–101.
- 11 Contingency management involves giving patients tangible rewards to reinforce positive behaviours such as abstinence.
- 12 Age-specific issues were reported as having comorbidities (physical and mental health); polydrug use; increased social exclusion; feelings of moral failing; fear of judgement within services; and stigmas due to mental health issues, thus preventing older drug users from accessing services.

HIV in Ireland: knowledge, attitudes and stigma

Recent research published by HIV Ireland examined national HIV knowledge and attitudes and the stigma associated with HIV.¹ HIV Ireland is a registered charity operating at local, national and European levels. The principal aim of the organisation is to contribute towards a significant reduction in the incidence and prevalence of HIV in Ireland and towards the realisation of an AIDS-free generation. The present study involved the development of two surveys. The first survey aimed to measure knowledge and attitudes among the general Irish population. The second survey measured stigma and the experiences of those living with HIV. Subjects were required to be 18 years of age or older and the surveys were completed by 1,013 and 168 respondents, respectively.

HIV knowledge and attitudes among the general public

Almost all adults (98%) correctly thought that HIV can be transmitted by sharing needles and syringes. A similar proportion correctly thought that HIV can be transmitted by a man and a woman, or a man and a man, having sex without a condom. However, the study found that myths in relation to HIV transmission remain and that young people had less correct knowledge than older people in relation to most methods of HIV transmission. Misperceptions regarding HIV transmission among the general public included the following:

- 70% of respondents believed HIV can be transmitted through a bite.
- 24% believed HIV can be transmitted through kissing.
- 10% believed HIV can be transmitted through sharing a glass.
- 9% believed HIV can be transmitted through using a public toilet.

The authors also noted that over one-half of respondents believed that HIV can be transmitted through a blood transfusion. While theoretically possible, this is not a reality given the safeguards and screening used in Ireland. HIV Ireland suggested that this assumption may negatively affect experiences of health services.

Stigma and experiences of those living with HIV

The second survey found that stigma and the fear of stigma affect how people living with HIV experience their lives. Around two-thirds (61%) of people feared being rejected in a relationship and around half of this number (32%) had actually been rejected. Fifty-four per cent of respondents were single compared to 38% in the general population.

The majority (61%) of people living with HIV had not disclosed their HIV status at some point, as they were afraid they would be judged or treated differently if they did. The stress that stigma can cause may explain why in the past year almost one in five (17%) respondents living with HIV had felt suicidal. More than one-third also reported having suffered from low self-esteem, anger, felt guilt or shame, and blamed themselves for their HIV status.

Other key findings among subjects living with HIV included the following:

- 88% thought that some members of the general public believe that living with HIV is shameful.
- 35% agreed that some people do not want to associate with them, and 38% believed that some people think they deserve to have HIV.
- A majority believed that it was more stigmatising to have contracted HIV through sex (76%) and through injecting drug use (67%).
- 18% of respondents living with HIV have had their HIV status disclosed accidentally in a hospital setting.

Conclusions

The authors suggest that knowledge in the general population regarding HIV transmission is relatively good, potentially highlighting the work done in relation to HIV awareness-raising in Ireland. Nevertheless, the study indicates that there is some room for improvement, in particular with regard to knowledge gaps and misperceptions among younger adults. Stigma still persists and affects the everyday lives of people living with HIV. While stigma is most sorely felt by the person immediately impacted upon, society at large is not immune from the effects resulting from HIV-related stigma, as it may reduce the likelihood of people getting tested. HIV Ireland hopes that this research will highlight these issues and provide data to support informed education, awareness-raising, and effective policy development.

Seán Millar

1 HIV Ireland (2017) *HIV in Ireland 2017: Findings from the (1) National HIV Knowledge and Attitudes Survey 2017 and (2) People Living with HIV Stigma Survey 2017. Summary report*. Dublin: HIV Ireland. <http://www.drugsandalcohol.ie/27920/>

Street-based injecting in Dublin city centre

Ireland's current drugs strategy emphasises a health-led response to drug use in Ireland.¹ Consistent with this focus, a pilot supervised injecting facility (SIF) will open in 2018 in Dublin city centre. As Ireland moves towards implementation of the country's first SIF, information with regard to public injecting among drug users in Dublin's inner city is important. A 2017 report from the Ana Liffey Drug Project (ALDP) examined street-based injecting in Dublin city centre.²

Harms associated with street-based injecting

The report highlighted the harms associated with street-based injecting. These include both private harms affecting individuals who are injecting and public harms which impinge on the community where injecting is occurring. Private harms include evidence suggesting that injecting in public places is conducive to hasty injecting, leading to safety and hygiene concerns. Public harms include drug-related litter in public and semi-public locations, thus creating a safety hazard to other individuals.

Street-based injecting in Dublin city

A small number of studies have attempted to assess the prevalence of street-based injecting among drug users in Dublin. In 2013, Merchants Quay Ireland reported that 14% of subjects who used their needle and syringe exchange service generally injected in public places.³ More recently, ALDP asked individuals who use their Dublin services to take part in a survey. It was found that 28% of respondents reported injecting drug use in the last seven days; 18% of respondents reported mostly injecting on the street or in a service during this time.

It was noted that the issues facing this group are many and complex, with polydrug use and sharing of paraphernalia being of particular concern. In addition, 28% of respondents in the ALDP survey indicated having prior experience of overdose. The risk of fatal overdose is a constant reality among street-based drug injectors. As the Health Service Executive notes:

Public injecting is visually apparent in Dublin city centre through people using drugs and from drug-related litter Between 2012 and 2014 there were 25 drug-related deaths among people who inject drugs in public places in Dublin and 18 drug-related deaths among people who inject drugs who were in touch with homeless services in Dublin.⁴

Public harms associated with street-based injecting

In late 2016, ALDP undertook a small project to document drug-related litter in the north inner city area of Dublin. Each afternoon a staff member walked two alternating routes in the area for two weeks; each route was covered every second day. In total, 57 separate instances of drug-related litter were identified, with over 1,750 individual pieces of litter being recorded. Litter was observed in a number of locations, but there were two 'hot spots': the area bounded by Capel Street, Ormond Square, Mary's Abbey and Ormond Quay, and that bounded by Jervis Street, Abbey Street Middle, O'Connell Street Lower and Ormond Quay.

Evidence of water for injection, citric acid and syringe caps were most frequently observed, and were recorded at 84%, 82% and 78% instances, respectively. Syringes were observed at 53% and needles at 51% of the total instances. Faeces were recorded at over one-quarter of locations, highlighting the lack of public toilets in the area.

Conclusions

The authors concluded that street-based injecting is an issue which requires attention in Dublin city centre, as the current situation perpetuates the use of high-risk environments by people who inject drugs as well as resulting in drug-related litter. Providing injecting drug users with the opportunity to access safer injecting spaces (such as supervised facilities) is a pragmatic approach to addressing this issue, as these services have repeatedly been shown to be effective in reducing harm, including overdose.⁵ Other interventions identified by ALDP included the following:

- Peer-led approaches to promoting safer disposal/return of drug-taking paraphernalia
- Continued outreach to identify people engaging in street-based injecting
- The removal of barriers that hinder the ability of people engaged in street-based injecting from accessing the services they require.

Seán Millar

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- 2 Keane M, Korovich M, Duffin T and Russell D (2017) *At the dark end of the street: a report on street based injecting in Dublin city centre*. Dublin: Ana Liffey Drug Project. <http://www.drugsandalcohol.ie/27953/>
- 3 Jennings CJ (2013) *Re-establishing contact: a profile of clients attending the Health Promotion Unit – needle exchange at Merchants Quay Ireland*. Dublin: Merchants Quay Ireland. <http://www.drugsandalcohol.ie/19914/>
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- 5 Potier C, Laprévote V, Dubois-Arber F, Cottencin O and Rolland B (2014) Supervised injection services: what has been demonstrated? A systematic literature review. *Drug Alcohol Depend*, 145: 48–68.

Merchants Quay Ireland annual review, 2016

Merchants Quay Ireland (MQI) is a national voluntary agency providing services for homeless people and drug users. There are 19 MQI locations in 12 counties in the Republic of Ireland. In September 2017, MQI published its annual review for 2016.¹ MQI aims to offer accessible, high-quality and effective services to people dealing with homelessness and addiction in order to meet their complex needs in a non-judgmental and compassionate way. This article highlights services provided by MQI to drug users in Ireland in 2016.

Open access services

Assertive Outreach Service (AOS)

In line with the MQI mission statement to reach out to the most vulnerable in society, this service aims to make contact with drug users not engaged with other services and to provide them with accessible support options. The geographical zone covered by the AOS is predominantly around each MQI location (Figure 1). Clients are assisted with clothing, food and drug treatment options. The service engaged with 116 individuals in specific casework, and with over 1,000 individuals on an informal support basis, throughout 2016.

Intensive Engagement Service (IES)

Many of the drug users who avail of MQI's open access services are homeless and have financial and legal problems. The MQI morning service (10am to 1pm) is a one-to-one support function called the Intensive Engagement Service (IES). The IES provides support with accommodation; drug treatment; and training, medical, welfare and legal issues. In 2016, some 929 individuals availed of the IES, with 75% of people seeking help with accessing accommodation.

Health Promotion Unit

This unit provides drug users with information about the risks associated with drug use and the means to minimise such risks. MQI offers drug users a pathway into treatment and the possibility of living a life without drugs. In the needle exchange and health promotion service, the main focus is on reducing the harms associated with injecting drug use; fostering the motivation to make positive change; giving advice on HIV, hepatitis B virus and hepatitis C virus infection prevention; and providing information on overdose and other risks. MQI also offers early referral to drug treatment services. In 2016, some 2,519 individuals used the service (a decrease of 6% on 2015), of which 421 were new clients.

As part of the MQI health promotion remit, a total of 2,139 safer injecting workshops were undertaken with injecting drug users in 2016, an increase of 30% on 2015. There were 25,603 needle exchange visits, a decrease of 1% on 2015.

Naloxone Demonstration Project

Along with partners in the Health Service Executive (HSE), the National Family Support Network and the Ana Liffey Drug Project, MQI was front and centre in the national rollout of the Naloxone Demonstration Project in 2015. Naloxone is an antidote for opioid overdose that reverses the depressant effects of opiates such as heroin. To date, more than 400

drug users have been prescribed naloxone, and an external evaluation concluded that the scheme was a success. MQI hopes that eventually all opiate drug users in Ireland will have access to this life-saving drug.

Family Support Group (FSG)

MQI offers one-to-one advice and support to family members on the realities of drug use and how they can best cope and provide optimum support to drug users. MQI also runs a Family Support Group (FSG), which meets every week and provides a forum where parents, as well as other close relatives and friends of drug users, are offered support and advice on a range of issues. Participants provide support for each other, and the group is continually open to new members. The weekly FSG is linked to the National Family Support Network, which offers an opportunity to raise issues at a national level. MQI's FSG in Dublin worked with 25 individuals throughout 2016.

Midlands Services

With support and funding from the Midland Regional Drug and Alcohol Task Force (MRDATF) and the HSE, MQI provides services in the four Midlands counties of Laois, Longford, Offaly and Westmeath. The MQI Family Support and Community Harm Reduction Team was established in late 2008 and provides dedicated outreach services for individuals actively using drugs.

Figure 1: MQI locations in Ireland



- 1 Dublin
- 2 Shelton Abbey, Co. Wicklow
- 3 St Francis Farm, Co. Carlow
- 4 Cork Prison
- 5 Limerick Prison
- 6 Co. Offaly
- 7 Co. Westmeath
- 8 Portlaoise, Co. Laois
- 9 Co. Longford
- 10 Castlerea Prison, Co. Roscommon
- 11 Loughran House, Co. Cavan
- 12 Leixlip, Co. Kildare

Source: MQI annual review, 2017

MQI annual review continued

It also provides services focused on the needs of the families of active drug users. The Midlands team consists of MQI staff, Department of Social Protection participants, those on work placement, and volunteers working across these four Midlands counties.

In November 2016, MQI was awarded the contract to provide a community-based drug and alcohol treatment support service for individuals over 18 years of age and their families for the Midlands area. This service will complement and enhance existing statutory, community and voluntary services operating in the region in line with best international research and standards. This reorientation of services will ensure a harmonisation of treatment supports across the Midlands Region, thus providing a more equitable and accessible service to all. Since the award of the contract, MQI have been engaged in transitioning the existing service to the new model of service delivery as required by the service contract.

Midlands Rehabilitation and Aftercare Service

MQI, with the support of the MRDATF and the HSE, established the Rehabilitation and Aftercare Service in September 2010. The purpose of this service is to provide a range of rehabilitation and aftercare supports targeting clients from the region, including those exiting drug treatment and prison. This involves assisting clients in the process of regaining their capacity for a daily life free from the impact of problem drug use and enabling their reintegration into the community. MQI workers provide case management for clients with a view to ensuring that all individuals have their needs assessed and have the opportunity to participate in developing a care plan, offering a pathway towards rehabilitation.

Workers also provide psychosocial support for persons leaving drug treatment or prison via one-to-one support and aftercare group work. This service worked with 75 individuals in 2016. The team liaised closely with interagency partners in order to address the underlying issues of addiction: accommodation, healthcare and abuse. Service users were both supported and challenged in terms of meeting their care plan goals and received one-to-one interventions and group support where required. There were 246 one-to-one sessions and 56 groups facilitated in 2016.

Midlands Family Support Services

These services involve the provision of interventions that support families in coping with addiction-related issues. Such services often include counselling, guidance and advice. Under the drugs strategy, family support is seen as increasingly important in the areas of drug treatment and prevention. MQI works to proactively link people with other support or treatment services that may be relevant to their needs. In 2016, MQI provided interventions that supported 78 family members in coping with addiction-related issues.

Midlands Community Harm Reduction Services

MQI is aware that local people and organisations are often very concerned about the level of public and community harm associated with drug use in their communities, as well as the risks to which drug users may expose themselves. MQI seeks to empower drug users and their friends and family with all of the information to ensure that they keep themselves safe. In the Midlands Region, the MQI Community Harm Reduction Service worked with 165 clients during 2016,

providing 2,309 harm reduction interventions. The service facilitated an average of 120 needle exchanges each month, operating in collaboration with the local pharmacy needle exchange scheme. MQI works on supporting clients in the 'pre-entry' phase before admission to residential rehab and detox. Nine clients from the Midlands Region entered MQI residential drug treatment during the course of 2016.

Drug-free treatment services

St Francis Farm (SFF) Residential Rehabilitation and Detox Services

The SFF Rehabilitation Service offers a 13-bed therapeutic facility with a 14-week rehabilitation programme set on a working farm in Co. Carlow. At SFF, MQI provides a safe environment where service users can explore the reasons for their drug use, adjust to life without drugs, learn effective coping mechanisms, and make positive choices about their future. There were 53 clients admitted to the SFF Rehabilitation Service during 2016; 37 (70%) male and 16 (30%) female. This represents a 4% increase in admissions compared with 2015.

The 10-bed residential detoxification service at SFF delivers methadone and combined methadone/benzodiazepine detoxes for both men and women. The detox activity programme includes individual care planning, therapeutic group work, psychoeducational workshops, fitness training, and farm-work activities. There were 72 clients admitted for detox service during 2016; 54 (75%) male and 18 (25%) female. This represents a 14% increase in admissions compared with 2015.

Prison-based services

MQI in partnership with the Irish Prison Service delivers a national prison-based Addiction Counselling Service (ACS) aimed at prisoners with drug and alcohol problems. This service provides structured assessments, one-to-one counselling, therapeutic group work, and multidisciplinary care, in addition to release-planning interventions with clearly defined treatment plans and goals. Services offered include:

- Brief interventions
- Motivational interviewing and motivational enhancement therapy
- A 12-step facilitation programme
- Relapse prevention and overdose reduction
- Cognitive behavioural therapy
- Harm reduction approaches
- Individual care planning and release planning

During 2016, some 2,624 prisoners accessed the ACS and the MQI team delivered 11,682 one-to-one counselling sessions and 3,033 group work attendances. The MQI ACS also coordinated and contributed to the delivery of a structured, multiagency eight-week Detox and Drug Treatment Programme (DTP) in the Mountjoy Prison Medical Unit. During 2016, the DTP assisted 80 prisoners in detoxing from methadone and benzodiazepines.

Seán Millar

1 Merchants Quay Ireland (2015) *Merchants Quay Ireland: annual review 2016*. Dublin: MQI. <http://www.drugsandalcohol.ie/27910/>

National Self-Harm Registry annual report, 2016

The 15th annual report from National Self-Harm Registry Ireland was published in late 2017.¹ The report contains information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in Ireland in 2016 and complete national coverage of cases treated. All individuals who were alive on admission to hospital following deliberate self-harm were included, along with the methods of deliberate self-harm that were used. Accidental overdoses of medication, street drugs or alcohol were not included.

Rates of self-harm

There were 11,485 recorded presentations of deliberate self-harm in 2016, involving 8,909 individuals. Taking the population into account, the age standardised rate of individuals presenting to hospital in the Republic of Ireland following self-harm was 206 per 100,000 population. This is similar to the rate recorded in 2015 (204 per 100,000 population). In recent years, there have been successive decreases in the self-harm rate between 2011 and 2013. Nevertheless, the rate in 2016 was still 10% higher than in 2007, the year before the economic recession (Figure 1).

In 2016, the national male rate of self-harm was 184 per 100,000 population, 1% lower than in 2015. The female rate was 229 per 100,000 population, which was 3% higher than in 2015. Since 2007, the male and female rates of self-harm have increased by 14% and 7%, respectively. With regard to age, the peak rate for men was in the 20–24-age group at 516 per 100,000 population. The peak rate for women was among 15–19-year-olds at 763 per 100,000 population.

Self-harm and drug and alcohol use

Intentional drug overdose was the most common form of deliberate self-harm reported in 2016, occurring in 7,646 (67%) of episodes. As observed in 2015, overdose rates were higher among women (72%) than among men (59%). Minor tranquillisers and antidepressants/mood stabilisers were involved in 35% and 19% of drug overdose acts, respectively. In total, 32% of male and 47% of female overdose cases involved analgesic drugs, most commonly paracetamol, which was involved in 30% of all drug overdose acts. In 69% of cases, the total number of tablets taken was known, with an average of 29 tablets taken in episodes of self-harm that involved a drug overdose.

There was no increase in the number of presentations involving street drugs (cannabis, ecstasy and cocaine) compared to 2015 (n=547). Nevertheless, the 2015/16 levels are the highest recorded since 2008 and the second highest ever recorded by the registry. Alcohol was involved in 31% of all self-harm presentations, and was significantly more often involved in male episodes of self-harm than females (34% vs 29%, respectively). The authors reported that, as in previous years, alcohol continued to be one of the factors associated with the higher rate of self-harm presentations on Sundays, Mondays and public holidays, and in the hours around midnight.

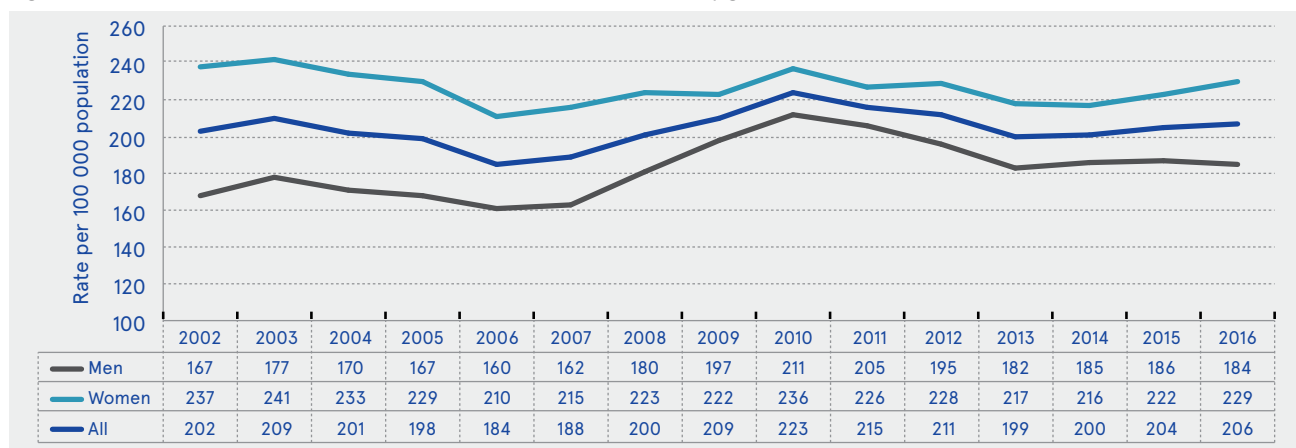
The authors concluded that these findings underline the need for ongoing efforts:

- To reduce access to minor tranquillisers and other frequently used drugs, including paracetamol
- To intensify national strategies to increase awareness of mental health issues
- To intensify further strategies to reduce access to alcohol.

Seán Millar

1 Griffin E, Arensman E, Corcoran P, Williamson E and Perry IJ (2017) *National Self-Harm Registry Ireland annual report 2016*. Cork: National Suicide Research Foundation. <http://www.drugsandalcohol.ie/27916/>

Figure 1: Person-based rate of deliberate self-harm from 2002 to 2016 by gender



Source: National Suicide Research Foundation, 2017

'All' in the legend refers to the rate for both men and women per 100,000 population.

Post-detoxification outcomes in opioid-dependent patients

There are currently in excess of 10,000 opioid-dependent patients receiving substitution therapy in Ireland,¹ with the majority of those attending detoxification receiving methadone. Given the weak evidence base with regard to the efficacy of detoxification, many clinicians opt to continue substitute-prescribing or may even dissuade opioid-dependent persons from detoxifying.

A small number of international studies have examined problem drug users in detoxification treatment. Follow-up studies have noted discernible reductions in heroin use as well as significant reductions in criminality, psychopathology, and injection-related health problems following treatment exposure.^{2,3,4} Nevertheless, the majority of these studies are limited to two time points and fail to take into account longitudinal changes. Importantly, no studies to date have focused on aftercare post-detoxification.

Recent research conducted in Ireland examined outcomes in a cohort of opioid-dependent patients post-detoxification.¹ In this study, which has been published in the journal *Drug and Alcohol Review*, patients completing detoxification in the three major Drug Dependency Units in Ireland during a 14-month period were examined (n=143). Subjects opting for one of the three pathways post-detoxification (inpatient aftercare, outpatient aftercare, or no formal aftercare) were assessed in the final week of detoxification and followed up after three, six and nine months. The primary outcome was abstinence following detoxification.

Results

An adjusted Cox regression model indicated that participants who opted for outpatient aftercare treatment had a lapse/relapse rate that was 52% higher than the inpatient aftercare group (hazard ratio [HR] 1.52, 95% confidence interval [CI] 0.75–3.08), although this difference was not statistically significant. Time to first use of drugs was considerably shorter for the no formal aftercare group (HR 7.68, 95% CI 4.30–13.73) when compared to those who received inpatient aftercare, highlighting that any aftercare is significantly better than no aftercare. Furthermore, patients who attended any form of aftercare were more likely than the no formal aftercare group to be abstinent at nine-month follow-up. Abstinence rates for outpatient aftercare and inpatient aftercare were found to be equal after nine months.

Conclusions

The authors concluded that patients who opt for aftercare post-detoxification have significantly better outcomes at follow-up when compared to no formal aftercare. In addition, the marginal benefit that the study demonstrated for inpatient aftercare over outpatient aftercare should be taken into account when planning services, as it is almost as effective and cheaper to provide.

Seán Millar

- 1 Ivers JH, Zgaga L, Sweeney B, Keenan E, Darker C, *et al.* (2017) A naturalistic longitudinal analysis of post-detoxification outcomes in opioid-dependent patients. *Drug Alcohol Rev* [forthcoming].
- 2 Ross J, Teesson M, Darke S, Lynskey M, Ali R, Ritter A, Cooke R (2005) The characteristics of heroin users entering treatment: findings from the Australian treatment outcome study (ATOS). *Drug Alcohol Rev*, 24(5): 411–18.
- 3 Teesson M, Ross J, Darke S, Lynskey M, Ali R, Ritter A, Cooke R (2006) One year outcomes for heroin dependence: findings from the Australian Treatment Outcome Study (ATOS). *Drug Alcohol Depend*, 83(2): 174–80.
- 4 Teesson M, Mills K, Ross J, Darke S, Williamson A, Havard A (2008) The impact of treatment on 3 years' outcome for heroin dependence: findings from the Australian Treatment Outcome Study (ATOS). *Addiction*, 103(1): 80–88.



Characteristics of methadone-related overdose deaths and comparisons between those dying on and off opioid agonist treatment

A national cohort study published online in *Heroin Addiction and Related Clinical Problems* aimed to describe characteristics of methadone-related overdose deaths in Ireland and to compare deaths occurring among those registered for opioid agonist treatment (OAT) with deaths among those not registered.¹ OAT involves the use of drugs such as methadone or buprenorphine to reduce cravings and withdrawal symptoms among those addicted to opioids such as heroin.

It is well established that OAT, including methadone substitution therapy, can reduce deaths among problem opiate users. However, OAT is also associated with a risk of accidental overdose, as patients can experience lowered tolerance for opioids following a period of abstinence. Individuals completing detoxification, leaving prison, or exiting OAT may therefore be especially vulnerable to accidental death by overdose. Previous research in Ireland found that people treated with methadone were nearly four times more likely to die in periods off treatment than in periods on treatment.²

Methodology

The current study drew on the Irish National Drug-Related Deaths Index (NDRDI) to identify persons who had died of a drug overdose involving methadone between 2012 and 2013. The NDRDI is an epidemiological database that draws on four sources – the Coroner Service, the Hospital Inpatients Enquiry Scheme, the Central Treatment List (CTL), and the General Mortality Register through the Central Statistics Office – to provide comprehensive data on drug-related deaths. The NDRDI classifies drug-related deaths as poisonings or non-poisonings (fatal overdoses), where ‘poisonings’ are deaths resulting from the toxic effects of the consumption of a drug(s) and/or other substances, and excludes adverse reactions to prescribed medications. Included in the current study were methadone-related poisoning deaths.

Findings

Methadone was implicated in 182 poisoning deaths that occurred during the study period. Just over half of the deaths were among persons aged 34 years or less (54%), and the majority of deaths were among males (78%). During the two-year period, more people died off OAT treatment (61%) than on OAT treatment (39%).

The study further found that a large number of methadone-related deaths were among persons previously treated for substance dependency, and many involved more than one substance. It was not possible to identify how many of those dying of fatal overdose were opioid dependent or were using diverted methadone for recreational or self-medicating purposes, nor was it clear how many had previous contact with OAT providers. Nonetheless, the findings suggest the targeting of overdose prevention interventions (such as overdose recognition, cardiopulmonary resuscitation, and naloxone) to those accessing all types of drug treatment services and not just those offering OAT. Over one-third of the fatal overdoses involving methadone were in patients registered for OAT, highlighting the unique position of OAT providers in risk assessment and overdose prevention. The finding that a high number of deaths occurred in a private dwelling and in the presence of others suggests that family and peers should also be involved in overdose prevention initiatives.

Limitations

A key limitation of the study is that the number of deaths off treatment may have been underestimated, as patients are not removed from the CTL until 28 days after treatment ceases. A further limitation is that it was not possible to differentiate between groups not registered for OAT, in particular those on waiting lists for OAT; those who just completed treatment; and those on buprenorphine. The study was also limited by the incomplete data for some variables, resulting from missing data in the original data sources accessible to the NDRDI. Access to a greater number of data sources would ensure more comprehensive data that could further inform the development and targeting of overdose prevention. The authors conclude that knowledge of patient characteristics, along with improved risk assessment and OAT retention strategies, can be used to inform any future national drug overdose plan.

Cathy Kelleher

- 1 Van Hout MC, Crowley D, Collins C, Barry A, Lyons S and Delargy I (2017) Characteristics of methadone-related overdose deaths and comparisons between those dying on and off opioid agonist treatment (OAT): a national cohort study. *Heroin Addict Relat Clin Probl* [Early online]. <http://www.drugsandalcohol.ie/27568/>
- 2 Cousins G, Boland F, Courtney B, Barry J, Lyons S and Fahey T (2016) Risk of mortality on and off methadone substitution treatment in primary care: a national cohort study. *Addiction*, 111(1): 73–82. <http://www.drugsandalcohol.ie/24374/>

POLICY AND LEGISLATION

Exploring drug-related public expenditure

Two reports have been published that explore drug-related public expenditure and the methodological challenges faced in estimating its value: *Public expenditure on supply reduction policies*¹ was published in May 2017, while *Drug treatment expenditure: a methodological overview*² was published in October 2017. The reports overlap extensively in terms of their descriptions of what drug-related public expenditure is, the context in which they were commissioned, and the overall messages from their findings.

What is drug-related public expenditure?

Public expenditure is defined as 'the value of goods and services purchased or utilised by the general government in order to perform each of its functions' (p. 15).² This includes any drug-related spending across the various functions of government, including healthcare, justice, public order, education, and social protection. Broadly speaking, drug-related public expenditure is described as 'labelled' or 'unlabelled'. Labelled drug-related expenditure is

*the ex-ante planned public expenditure made by general government in the budget that reflects the public and voluntary commitment of a country in the field of drugs. In addition, it is any expenditure identified as drug-related in public accountancy documents.*¹ (p. 23)

In the Irish context, this would include budget allocations for the Health Service Executive (HSE) addiction services and treatment services in prison, for example. Unlabelled drug-related expenditure is

*the non-planned or non-publicly announced ex-post public expenditure incurred by the general government in tackling drugs that is not identified as drug-related in the budget.*¹ (p. 24)

This would include, for example, the cost incurred for the imprisonment of people for drug-related offences. Total drug-related public expenditure is the sum of both labelled and unlabelled expenditure.

Context of reports

Internationally, there are growing demands on governments to support effective responses to problematic drug use. However, simultaneously, budgets for both supply and demand reduction activities have tended to decrease as a consequence of austerity measures implemented following the 2008 recession. This has contributed to a context where 'ensuring value for money in public investment [is] high up on the political agenda' (p. 179).² It is within this context that there is a need for governments to carry out rigorous policy evaluations that include an economic assessment. This will support better decision-making about where to allocate

resources. Being able to quantify a government's drug-related public expenditure is a key step in carrying out any economic evaluation of its drug policy interventions.

*In this economic climate, more than ever, policymakers and service planners require data and information on the capacity, performance and costs of national treatment systems in order to support investment decisions and to make sound policy choices.*² (p. 5)

This move towards improving understanding of drug-related public expenditure and its accurate measurement is reflected in European Union (EU) policy. One of the 15 overarching indicators for measuring the achievements of the EU action plan on drugs (2017–2020) includes developing national evaluations and public expenditure estimates.³ Despite this, it is a methodological area in which knowledge is described as 'sparse' (p. 5).¹ To address this gap, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has been given the role of 'developing analytical instruments to better assess the effectiveness and impact of drug policy using a number of tools including the analysis of public expenditure' (p. 5).² These reports were commissioned as part of this effort.

Supply reduction public expenditure

Public expenditure on supply reduction policies provides an overview of the key concepts involved in estimating public expenditure. While focused on supply reduction, the report offers a very useful introduction to the field of drug-related public expenditure more generally. It explains in an accessible way the core concepts involved and outlines the key steps in cost estimation and analysis.⁴ For example, it describes the international classifications for the functions of government used in this field (Reuters and COFOG), as well as a detailed description of the characteristics of labelled and unlabelled expenditure.

Supply reduction initiatives are defined as those comprising 'the whole system of laws, regulatory measures, courses of action and funding priorities concerning illicit drugs put into effect by a government or its representatives' (p. 8)¹ (e.g. police and customs officers and judges). The report outlines examples of models for estimating unlabelled supply reduction activity in related sectors – the police, customs and prison services as well as court systems. A sample of national studies which have applied models for estimating labelled and unlabelled expenditure on supply reduction are also described.

The report concludes with a set of recommendations that focus on improving the quality of data and methodological approaches to analysis. There is a particular focus on the need for consistency in classification of the data and for partnership working with all relevant stakeholders in the field.

Drug treatment expenditure

Drug treatment expenditure: a methodological overview is a much more substantial report than that on supply reduction policies. It gathers together detailed methodological papers from across the globe to provide an overview of 'the current state of the art in this field' (p. 179).² While it indicates a growing interest and level of research activity on the topic, the authors describe it as still being in its 'infancy' (p. 179).² The report highlights the methodological complexities of the topic, with much discussion on the challenges faced

Drug-related public expenditure

continued

in carrying out this work. It highlights the need for more agreement on common definitions and improved data sources. The main body of the report is broken down into five sections, each of which focuses on broadly different methodological approaches taken on the topic.

- 'Towards an overall estimate of public expenditure on drug treatment' describes the approach taken by a team in Australia to provide an overall estimate of drug treatment expenditure. It highlights the methodological challenges in doing so, including being unable to isolate expenditure on treatment for alcohol misuse from that on drug treatment.
- The second and third sections present the methods used when focusing on labelled (three studies) or unlabelled expenditure (five studies), respectively.
- 'Other tools to measure the costs of drug-related harm' contains two studies. The first describes a 'calculator' developed by Public Health England which can be used by local authorities in their appraisal of their spending on drug-related interventions. The second explores the issue of cost sensitivity in relation to the delivery of services across teams – how much would costs increase if established drug treatment teams were to increase their activity?
- The fifth section is about 'contextualising costs'. It presents the findings of three diverse studies which show that public expenditure on drug treatment is only part of the picture when exploring costs. They highlight the importance of placing public spending estimates in the right context. It addresses questions such as how should estimates on drug treatment vary if a significant amount of costs are borne by the private sector.

The final substantive section of the report identifies the main methodological commonalities and considerations from across the studies. The authors conclude with a set of 10 'good practices' (p. 188)² that they suggest could be used to improve estimates of public expenditure on drug treatment. These include to:

- Ensure that clearly defined aims and objectives are developed for each exercise, and note that these may differ from case to case.

- Develop a clear definition of drug treatment for the study, including the operational definition applied in estimates. This should help to clarify the scope and objective of estimates.
- Develop a map of treatment provision and funding flows. This exercise will help identify missing data, minimise the risk of double counting and facilitate assessment of the coverage of estimates.
- Analyse all levels of government activity, budgets and/or fiscal-end accountancy reports to identify labelled expenditure on drug treatment, as responsibility for financing drug treatment can lie with multiple actors (p. 188).²

Key messages

While exploring different aspects of drug policy, there was much overlap in the findings of these reports. Both argue the importance of being able to calculate drug-related public expenditure if policy-makers are to be able to make decisions about the most cost-efficient approaches to addressing problematic drug use. They found numerous challenges to collecting and comparing drug-related expenditure across jurisdictions, with different political structures and government accounting systems. An absence of commonly agreed definitions and methodologies, a lack of comparable datasets, and uncertainty about which economic models to use, were identified in both reports as barriers to the rapid development of policy evaluation and cost-effective analysis.

Lucy Dillon

- 1 Bretteville-Jensen AL, Costa Storti C, Kattau T, Mikulic S, Trigueiros F, Papamalis F, et al. (EMCDDA) (2017) *Public expenditure on supply reduction policies*. Brussels: Council of Europe. <http://www.drugsandalcohol.ie/27458/>
- 2 European Monitoring Centre for Drugs and Drug Addiction (2017) *Drug treatment expenditure: a methodological overview, EMCDDA Insights 24*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/28010/>
- 3 European Commission (2017) *EU action plan on drugs 2017–2020*. Brussels: Council of the European Union. <http://www.drugsandalcohol.ie/27680/>
- 4 Another *Drugnet* article also explains the basic concepts of drug-related public expenditure in some detail. See Pike B (2008) Understanding drug-related public expenditure. *Drugnet Ireland*, 27: 23–24. <http://www.drugsandalcohol.ie/12125/>

Ireland, Irishness and alcohol: changing the relationship

In November 2017, over 150 people attended two timely events in Letterkenny, Co. Donegal as part of the fourth National Conference of the Alcohol Forum, which aimed to challenge the narrative around the cultural inevitability of alcohol harm in Ireland.

The conference 'Ireland, Irishness and Alcohol: Changing the Relationship' explored the historical, social and cultural factors that have shaped and maintained Ireland's problematic relationship with alcohol and examined how notions of culture are exploited by the global alcohol industry. The conference offered new theoretical and policy perspectives for understanding, challenging and changing the Irish relationship with harmful drinking. It also brought together diverse speakers from Ireland and the USA and from a range of different disciplines.

The opening event was a screening of the Irish-American film *Emerald City* in the Regional Cultural Centre, Letterkenny. The film explored the struggles with alcohol, mental health and identity among a group of Irish immigrant construction

workers in 1990's New York. The event was attended by film-maker Colin Broderick, who had travelled from the US to be part of the evening. A frank and honest panel discussion, exploring the impact of alcohol on families, was chaired by Denis Bradley, who was joined by Colin, Donna Butler from the Alcohol Forum's Families Matter programme and Rachel Reisman from the Irish International Immigrant Center in Boston.

A day-long conference was held the next day in Letterkenny Institute of Technology. Setting the context and providing information on the level of alcohol harm in Ireland, Dr Jean Long of the Health Research Board was the keynote speaker. She provided an analysis of the relationship between patterns of consumption and levels of harm in a population, highlighting the fact that in the 32-year period, 1984 to 2016, alcohol consumption in Ireland trebled and, despite an overall decrease since 2001, consumption in 2016 rose by 500 ml per person to 11.5 litres.

There followed presentations by historian Dr Gearóid Ó Tuathaigh, former dean of arts in NUI Galway, and social worker Rachel Reisman from the Irish International Immigrant Center. Dr Ó Tuathaigh explored some of the historical forces that shaped the construction of the negative Irish stereotype, including the description of the 'native' and 'Gaelic' as lesser, uncivilised and drunken at various points throughout a history of colonialism. He concluded that while stereotypes can be persistent they are by no means fixed or inevitable. A member of the Council of State, he also spoke about the potential power of symbolic leadership, referring to the entertaining of foreign dignitaries and heads of state at the Guinness Store House. With a rich history and heritage, there are vast opportunities for Government to show leadership on this issue. Rachel Reisman further emphasised the power of leadership in changing attitudes and breaking the stigma, pointing to the huge support there has been for Boston Mayor Marty Walsh in making public his own recovery journey from alcohol. The chair for the morning session, RTÉ journalist Tommie Gorman, highlighted the power of including a diaspora perspective: 'I think it's a really clever programme; sometimes it's useful to look at ourselves from the outside.'

The afternoon continued with the interdisciplinary approach, opening with global alcohol marketing expert Dr David Jernigan, former adviser to both the World Health Organization and the World Bank. This was followed by a presentation of the work of the National Community Action on Alcohol by Paula Leonard from the Alcohol Forum. Paula highlighted the growth in the numbers of communities which now have developed or are currently developing local community action on alcohol plans. Although diverse and

About the Alcohol Forum

The Alcohol Forum supports children, families, individuals, and communities affected by alcohol. Founded in Donegal in 2007, the charity has a national programme aimed at delivering its vision of an Ireland where every child, family and community is free from the harmful effects of alcohol. Its work is an evidence-informed response to the harm caused by alcohol misuse in communities across Ireland. Since the Alcohol Forum's formation as an interagency forum, the work of the charity has been underpinned by an understanding that partnership working and wide sectoral and community engagement are required for any real change to be achieved in reducing alcohol harm in Ireland.

Alcohol Forum, Unit B9 Enterprise Fund Business Centre, Ballyrairie, Letterkenny, Co. Donegal

For more information, contact Mariclare Gallagher at mariclare@alcoholforum.org or phone 074 912 5596. Website: www.alcoholforum.org

responding to local needs, all plans are underpinned by a clear public health approach, including actions on issues such as licensing, advertising, availability and underage supply. In the plenary discussion, Dr Jernigan commended the work of the Community Action on Alcohol Programme and its clear focus on and understanding of a public health approach. Professor Frank Murray and Senator Frances Black joined the afternoon plenary session, with both calling for increased public support for the Public Health (Alcohol) Bill 2015. Marian Harkin MEP, who chaired the afternoon discussion, welcomed the way in which the conference had approached the issues:

It is very clear from today that we are talking about the regulation of the alcohol industry and not about regulating the individual choices that people make. This is an important way of having the conversation and I congratulate you all on a brilliant event.

Tackling alcohol harm locally and globally will require action from a wide range of sectors and individuals. Involving film-makers, historians, social workers, public health experts and political representatives, the conference offered a broader approach to the issues, moving beyond health and enabling us to explore a variety of different perspectives. The formula, based on the feedback from many of those who participated on the day, worked.

Paula Leonard



Kieran Doherty of the CEO, the Alcohol Forum, with other members of the forum, conference speakers and delegates at 'Ireland, Irishness and Alcohol: Changing the Relationship' in Letterkenny in November 2017

RESPONSES

EMCDDA publishes guide on evidence-based responses to drug problems

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) aims to provide a comprehensive picture of the drug phenomenon in Europe and the responses to drug problems to help policy-makers and practitioners develop and implement effective policies and interventions. The recently published *Health and social responses to drug problems: a European guide*¹ forms an important part of this overall picture and provides practitioners with a useful roadmap for managing interventions.

Responses can be defined as 'any actions or interventions that are undertaken to address the negative consequences associated with the illicit drugs phenomenon' (p. 9). Responses on the supply side are covered in the *EU drug markets report*.²

The authors of the guide were faced with a number of challenges. Within Europe the drug situation is very varied, many different drugs are being used, the contexts of this usage vary, and there are different stages of development of drug problems in different areas. So, there is no simple blueprint for the responses that should be put in place. Further, drug problems can change rapidly and vary over time, so a regular review of the policies and responses is necessary.

To address these challenges the report provides:

- A way of thinking about how to respond to drug problems in a particular country or local area and identify what is needed and likely to be appropriate to a particular situation.
- A brief overview of current knowledge that attempts to answer what can be done, what works, and what we know about what is currently being provided in Europe.

- A highlight of some key issues, for example, developing areas such as e-health, and links to more detailed information on these topics.
- A platform for ongoing work in the health and social responses area.

The report is part of a package which includes a range of additional materials online that will be added to and regularly updated.³

These policy and practice briefings provide:

- A summary of the main issues, response options, and some information about what is happening in Europe
- A summary of the evidence for responses in that particular area
- The key implications for policy and practice
- Links to further resources

The webpage provides links to a range of background papers that were commissioned to help in drafting the report. These include an evidence review summary, and others dealing with a range of 'hot topics', such as addressing the needs of the ageing cohort of opiate users seen in many countries, drug-checking services, e-health, and how to use behavioural insights to improve the effectiveness of responses.

The best practice links include:

- The Best Practice Portal evidence registry where you can search for evidence on particular topics; and
- The Xchange registry, which provides information on individual programmes and the people and places in which they have been used. This is currently mainly prevention programmes but will be expanded to include other types of interventions in the future.

This report is not in the traditional report style and adopts a new format inspired by the idea of a travel guide. It is focused on how to respond to different drug problems rather than giving details about the extent and nature of drug problems. This information is covered in the *European drug report 2017*.⁴

It is action-orientated rather than in textbook style. It is, inevitably, a brief overview of each topic, but easy to read and providing links to more detailed information.

Figure 1: The three broad stages of developing responses to drug problems

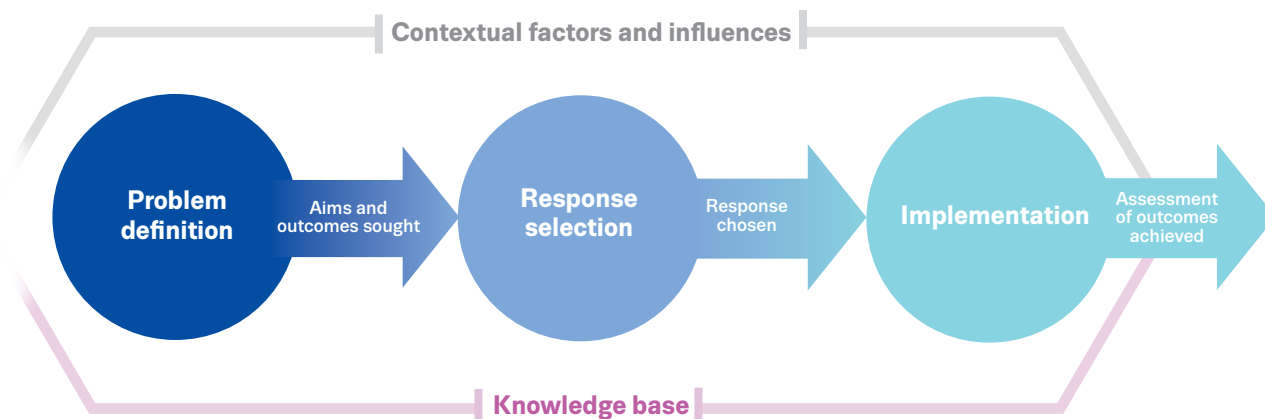
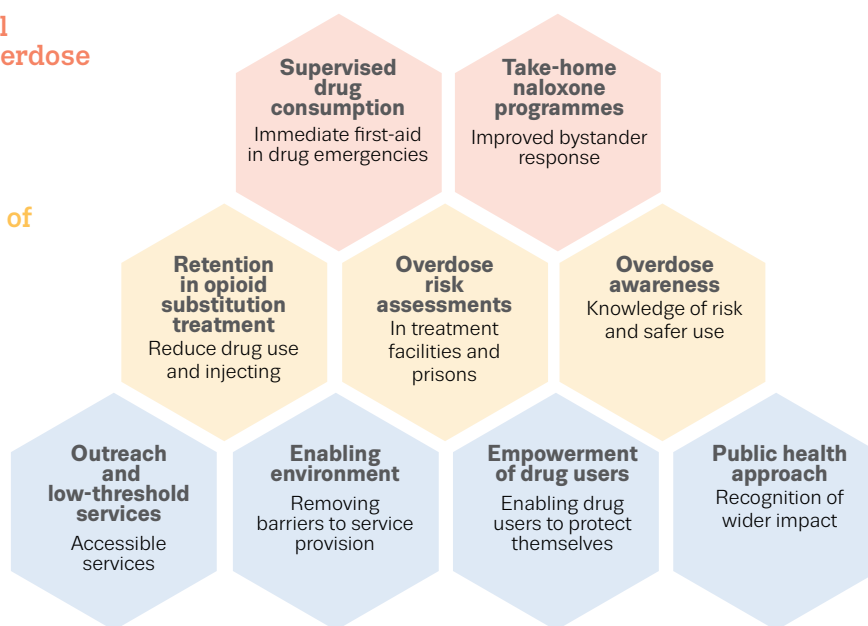


Figure 2: Interventions to reduce the risk to opioid-related deaths

Reducing fatal outcome of overdose**Reducing risk of overdose****Reducing vulnerability**

The guide is intended as a reference document with clear signposting, and uses boxes and colour coding to make it easier to scan. Boxes and sections have different icons depending on the type of material they contain.

The report has five main chapters, topped and tailed by an introduction and concluding remarks. Chapter 1 discusses the different factors that need to be considered in developing responses to drug problems. Chapters 2, 3 and 4 consider what we know about responding to different drug problems, viewed from three different perspectives: responding to problems arising from use of different drugs or types of use; responding to the needs of particular groups of individuals; and, responding in different settings. Chapter 5 looks at ways of supporting the successful implementation of responses.

Chapter 1 presents a way of thinking about the whole process of responding to drug problems.

An example from this chapter is tackling opioid-related deaths, which are increasing in a number of countries. The chapter highlights a range of response options that seek to reduce the risk of death:

- At the bottom of the 'pyramid' are wider public health interventions that aim to make opioid users less vulnerable to overdose.
- In the middle are interventions that make it less likely that people who use opioids will overdose – retaining them in opioid substitution treatment, assessing their risk of overdose, and raising their awareness of the dangers of overdose.
- Finally, at the top, are interventions that can prevent deaths when overdoses do occur – the widespread availability of naloxone, which can reverse overdoses, and supervised drug consumption rooms in which immediate first aid can be given if overdose does occur.

The implications for policy and practice highlight the importance of improving provision of the programmes already mentioned. For example: improving drug users'

awareness of overdose risk situations and behaviour, such as the dangers of combined use of central nervous system depressants – opioids, alcohol and benzodiazepines; and training potential bystanders to detect overdose signs and to respond accordingly. These include drug users, peers, family, healthcare and social services staff, and the police.

Another aspect is improving prison-to-the-community throughcare. This is a period of particularly high risk of overdose deaths. This section also looks at barriers to the establishment of drug consumption rooms in areas with lots of street injecting and addressing legal obstacles to calling the police (Good Samaritan laws).

Chapter 3 looks at responses from the perspective of different target groups.

As an example, one section of this chapter looks at responses in nightlife, festivals and other recreational settings. Here there are a range of response options, and multi-component, multiagency approaches appear most successful. These will often target alcohol as well as drug use

These responses include:

- Providing information and education to drug users to reduce harms.
- Environmental strategies, such as regulating venues, e.g. limiting happy hour promotions and other factors that promote dangerous consumption patterns; providing chill-out rooms, free water and cheap soft drinks; training of staff and ensuring first aid and emergency responses are available.
- Establishing drug-checking services that can provide alerts, advice and brief interventions to reduce harms as well as information for early warning systems and market monitoring.

There is increasing interest across Europe in establishing drug-checking services, for which there are many different models. One background paper provides more detail on these (including the map in Figure 3).

EMCDDA guide to health responses continued

Chapter 5 focuses on ways to support successful implementation

An evidence-based programme will only be successful if it is well implemented. The first section of this chapter looks at ways of encouraging the use of evidence in practice, and it considers the challenge of transferring programmes into different cultural contexts, how quality standards and guidelines can be used to improve the effectiveness of services, and the importance of sharing best practice.

It highlights as implications for policy and practice the potential benefits of:

- Implementing the European minimum quality standards for demand reduction and the establishment of national standards and guidelines; and
- The further development of best practice exchange websites and other e-health support tools.

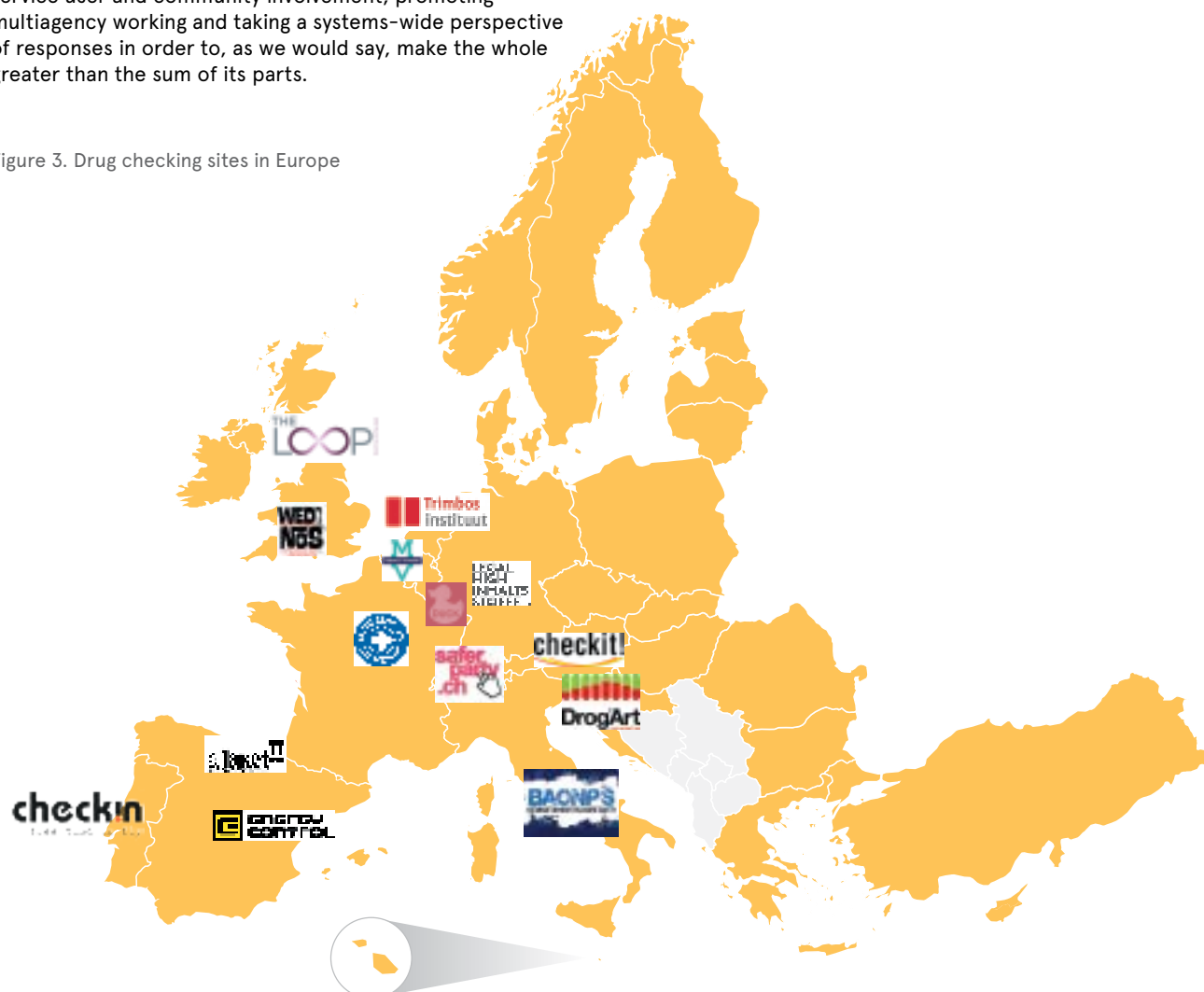
Section 5.2 focuses on the importance of supporting the people and organisations involved and considering systems and partnerships in order to promote effective delivery. It highlights the importance of training and staff development, service user and community involvement, promoting multiagency working and taking a systems-wide perspective of responses in order to, as we would say, make the whole greater than the sum of its parts.

The final section is on the importance of monitoring and evaluation to promote learning from experience and continuous improvement in outcomes.

Brian Galvin

- 1 European Monitoring Centre for Drugs and Drug Addiction. (2017) *Health and social responses to drug problems: a European guide*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/28040/>
- 2 European Monitoring Centre for Drugs and Drug Addiction and Europol. (2016) *EU drug markets report: in-depth analysis*. Luxembourg: Publications Office of the European Union. <http://www.drugsandalcohol.ie/25357/>
- 3 The report and the other materials can be accessed through a webpage on the EMCDDA website: <http://www.emcdda.europa.eu/responses-guide>. From there you can download an electronic version of the guide as a PDF (an e-book format will be available in the future). From the second tab, you can get access to policy and practice briefings, covering each of the topics in the guide. From the fourth tab, there are links to a range of further resources, including best practice databases, topic pages, and more detailed reports related to the topics in the guide.
- 4 European Monitoring Centre for Drugs and Drug Addiction. (2017) *European drug report 2017 trends and developments*. Luxembourg: Publications Office of the European Union. Available online at http://www.emcdda.europa.eu/edr2017_en

Figure 3. Drug checking sites in Europe



Ten-year celebration of National Family Support Network

The National Family Support Network (NFSN)¹ is a self-help organisation supporting the development of family support groups and networks throughout Ireland. Through their work they raise awareness of the difficulties faced by families in coping with substance misuse, while recognising the important role that families play in supporting the recovery of the substance-misusing family member.

Autonomous national organisation

Although founded in 2000, 2017 marked the 10-year anniversary of the NFSN gaining recognition as an autonomous national organisation. To mark this date, friends and stakeholders gathered in St Andrew's Resource Centre on Pearse Street, Dublin, on 6 December 2017, to hear speakers talk about the importance of the work that NFSN does. Speakers included Susan Scally from the Drugs Policy Unit of the Department of Health; Anna Quigley from CityWide Drugs Crisis Campaign²; former Assistant Garda Commissioner Tony Hickey; researcher Philip Isard; family support facilitator Maureen Penrose; parent Brigid Sugrue; and the main speaker and founder, Sadie Grace.

Sadie spoke with passion and emotion when she recalled how far the NFSN has come and its achievements of the last number of years. From humble beginnings, the NFSN was established in response to the lack of services available for families to where it is today, shaping national policies, carrying out research, advocating and lobbying for family rights. The NFSN's work in highlighting the support that families provide received the ultimate accolade when the national drugs strategy formally recognised family members of substance misuse as 'service users'.³ This milestone event is proof positive of the work being done by the NFSN.

Impact of NFSN

Susan Scally from the Drugs Policy Unit outlined the effect that the NFSN has had on shaping the national drugs strategy (2017–2025). Its family and community insight fed the extensive consultation process in forming the national drugs strategy. Next, Anna Quigley of CityWide took us on a whistle-stop tour of the organisation and their partnership with the NFSN from the 1980s – where there was much stigmatisation around drug misuse and where the focus lay with politicians and policy-makers – through to today, where communities and families have a clear input into policies and procedures governing drug misuse. Anna spoke warmly of the first service of commemoration organised by the NFSN in 2000, which became a catalyst for their subsequent work. She spoke of the ardent appeal for more accurate reporting of drug-related deaths, which they knew were being under-reported, and which eventually contributed to the creation of the National Drug-Related Deaths Index (NDRDI).⁴ She spoke of how the NFSN contributed to research carried out by the National Advisory Committee on Drugs and Alcohol on the impact of drug misuse in families.⁵ In addition, its contributions to the move towards the decriminalisation of narcotics in 2015 for personal use was another long fought-for appeal by the NFSN to support people and not punish them. National conferences and working with various organisations to publish reports are among the many strings to its bow.

Tony Hickey, former Assistant Garda Commissioner and board member of the NFSN, had the audience nodding in agreement and in laughter, and sometimes gasping, as he told anecdotes of his time working as a guard on the streets of Dublin. He recounted how Ireland could be a judgemental society but that families have worked hard to change attitudes.

Launch of report

The event was also an occasion to launch the report, *Valuing family support: a social return on investment report on the value of family support for families coping with addiction issues*.⁶



The NFSN team: Clara Leonard (office manager), Conor Byrne (development worker), Sadie Grace (CEO), Ger Doherty (membership officer), Aoife Frances (policy officer), and Christy Rankin (training officer)

NFSN – 10 years continued

Philip Isard of Quality Matters⁷ outlined his research with the NFSN. Its collaboration was an attempt to understand the social and financial benefit of family support for individuals and the wider impact on families and organisations in Ireland.

With a lack of research on the impact of family support, the study involved the Gardaí, Tusla, NFSN, Local and Regional Drug and Alcohol Task Forces, local addiction services, drug users and, of course, families themselves. Using the social return on investment (SROI)⁸ methodology, the report states that for every €1 invested in the NFSN, it puts back at least €5 into the community. As the saying goes, 'money talks' and what could be more telling than this figure. The report was reviewed and verified by Social Value International⁹ and provides evidence of what families already knew but which is now confirmed.

Personal testimonies

To remind the audience of the realities for families living with substance misuse, Brigid Sugrue, a mother directly impacted by drugs misuse and ultimately death, told her story. In an often emotional speech, Brigid spoke of the 'lifeline' that was the Bereavement Support Programme of the NFSN and reiterated the importance of the work of NFSN. Also 'on stage' was Maureen Penrose, who spoke eloquently about the first of many services of commemoration: 'We're suffering, we're many, we have a voice.' She spoke of how you 'won't cry alone in the NFSN' and that 'you're always supported'.

The event finished with a video summarising the work of the NFSN, including the establishment of its Drug-Related Intimidation Programme; its five-step method; statistics from the NDRDI to advocate for services; the Young Person's Support Programme, and much more.

Anne Doyle

- 1 For further information on the National Family Support Network, visit <http://www.fsn.ie>
- 2 For further information on the CityWide Drugs Crisis Campaign, visit <https://www.citywide.ie/>
- 3 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27603/>
- 4 For further information on the National Drug-Related Deaths Index (NDRDI), visit <http://www.hrb.ie/health-information-in-house-research/alcohol-drugs/ndrdi/>
- 5 For further information on the National Advisory Committee on Drugs and Alcohol, visit <http://www.nacda.ie/>
- 6 Isard P (2016) *Valuing family support: a social return on investment report on the value of family support for families coping with addiction issues*. Dublin: National Family Support Network. Available online at <http://www.socialvalueuk.org/app/uploads/2017/02/Valuing-Family-Support-National-Family-Support-Network-SROI-.pdf>
- 7 For further information on the organisation Quality Matters, visit <http://qualitymatters.ie/>
- 8 SROI is an increasingly well-used and highly regarded new methodology that enables organisations to examine the impact of their work and place a financial value on it.
- 9 For further information on Social Value International, visit <http://socialvalueint.org/>

EUSPR conference: quality in prevention

The 8th Conference of the European Society for Prevention Research (EUSPR) was held in Vienna between 20 and 22 September 2017. As reported previously in *Drugnet Ireland*,¹ the EUSPR was established to promote 'the development of prevention science, and its application to practice so as to promote human health and well-being through high quality research, evidence based interventions, policies and practices'.² The cornerstones of its work are a cross-disciplinary network of scientists, policy-makers and practitioners; the development of methodologies; the promotion of higher education and career development in prevention; and the implementation of research.

The conference theme for 2017 was 'Quality in Prevention' and plenary speakers addressed a range of topics on the theme,³ including:

- How to attain and maintain quality in an evidence-based programme
- The implementation of suicide prevention in existing measures of addiction prevention

- How to support a professional culture of quality in prevention
- What are the consequences of prevention policies?
- Rethinking the dynamics of primary prevention: mobilisation, implementation, and embeddedness in open systems

Speakers represented the international community working in the area of prevention. Posters and parallel session presentations covered a wide range of topics, including programme evaluations, methodological approaches, and broader debates on the role and value of prevention.

Preventing substance use was just one of the behaviours addressed in the conference. Related presentations included an update of the International Standards on Drug Use Prevention from the United Nations Office on Drugs and Crime (UNODC),⁴ originally launched in 2013. These standards are currently being updated to take account of progress made in prevention research and to ensure the standards provide guidance based on the most up-to-date evidence on what makes effective prevention. The team conducting this work will carry out a systematic review of reviews and a review of primary studies to capture 'the research on the emerging areas of prevention, not yet accumulated enough to register at the level of reviews' (p. 30).⁵

EUSPR conference continued

Irish papers presented at the conference included:

- 'Because we do it together' family based prevention: a ten-year overview of implementation and outcomes of the Strengthening Families Programme in Ireland', presented by Donna Butler of the Families Matter Programme.
- 'Factors concerning access to a potential drug consumption room', presented by Emma Atkin-Brenninkmeyer of Trinity College Dublin.
- 'Getting prevention on the political agenda: the Irish experience of influencing policy and practice', presented by Marian Quinn of the Prevention and Early Intervention Network.
- 'Alcohol drinking behaviours and perceived norms: longitudinal trends among Irish adolescents aged 12–15 years', presented by Kathy-Ann Fox of the National University of Ireland, Galway.

Conference on drug use in families and communities

On 22 November 2017, a community conference 'Drug use in families and communities: reducing harm, supporting recovery' took place as part of Bray Drugs Awareness Month. The event was coordinated by the Bray Drugs Awareness Forum (BDAF). BDAF was established in 1992 and comprises representatives from community, voluntary and statutory organisations, all with a shared interest in drugs issues. The forum works to provide education, awareness, prevention, training, and information on drugs issues for the Bray community.

Approximately 100 people attended the conference, including members of the forum and other stakeholders working in the sector in the Bray area, as well as members of the wider community. The programme included a presentation from Anna Quigley of CityWide Drugs Crisis Campaign on the new national drugs strategy. She presented an overview of the strategy and identified some key challenges to its delivery: challenges to sustaining an interagency partnership approach; those related to local community involvement, including the impact of cuts on local drugs services and general community services; and, features of the overall environment in which the strategy is to be delivered, for example, the lobbying power of the alcohol industry and the increasing complexity of drugs and their markets.

Lucy Dillon

- 1 Dillon L (2017) EUSPR conference: sustainable prevention in a changing world. *Drugnet Ireland*, 61: 21. <http://www.drugsandalcohol.ie/27212/>
- 2 More information on the EUSPR and the conference is available at www.euspr.org.
- 3 Plenary speakers' presentations are available to download at <http://euspr.org/plenary-talks/>
- 4 United Nations Office on Drugs and Crime (UNODC) (2015) *International standards on drug use prevention*. Vienna: UNODC. <http://www.drugsandalcohol.ie/19481>
- 5 European Society for Prevention Research (2017) *Quality in prevention: 8th EUSPR Conference and Members' Meeting: Vienna, 20th–22nd September 2017*. Warsaw: EUSPR. <http://www.drugsandalcohol.ie/27987/>

Professor Catherine Comiskey and Karen Gilligan of Trinity College Dublin presented on research they carried out to develop a family and community informed local drugs strategy for children of parents who use drugs. Clara Geaney of Ballyfermot Local Drugs and Alcohol Task Force presented the findings of her research on women, alcohol, health, and treatment. The goals of the study were to support screening assessment and treatment for women experiencing problematic alcohol use within primary care settings; and to strengthen referral between primary care services and specialised substance misuse services.

Presentations were also made by Adrian McKenna of Crosscare Homeless Services and Maureen Penrose, a drug worker who previously worked with Mountview/Blakestown Community Drugs Team. Adrian spoke of the increasing demand on their services and the diverse needs of their users. He also highlighted the need for people to be given permanent rather than temporary accommodation. Maureen spoke of her experiences of supporting families of drug users. She also presented her spoken word piece entitled 'Grandmothers'.¹

Further information on the conference can be obtained from Dr Clay Darcy, drugs education and prevention development officer who works on behalf of the BDAF, at braydrugsawarenessforum@gmail.com.

Lucy Dillon

- 1 The video of Maureen Penrose can be viewed at http://www.drugs.ie/multimedia/video/grandmothers_by_maureen_penrose

Rethinking the response to cannabis use

The study *'It's only weed': rethinking our response to young people's cannabis use in Ballymun* was carried out by Ballymun Youth Action Project, and published in May 2017.¹ Service providers based in Ballymun, Dublin who work with early school-leavers (aged 16–24 years)² noticed that a cohort of young people were becoming increasingly difficult to motivate both to turn up for appointments and to engage with when attending key working sessions. It was decided to explore the factors that were impacting on retention and progression rates for this group. Through discussions among key stakeholders, cannabis use was identified as contributing to the problem; programme participants were reporting both 'high levels of use and, for some, high levels of drug debt' (p. 6). The research had two aims:

- To provide a rapid assessment of cannabis use prevalence within particular education/training centres and community settings in Ballymun
- To explore the relationship that the young people in these settings have with cannabis

Data were collected from young people attending two youth education/training projects and one 'street' site, i.e. young people not engaged in any education and training programme. A questionnaire was developed based on the 'existing evidence based tool', i.e. the cannabis use problem identification tool (CUPIT) (p. 12). Overall, 73 young people from the training projects took part and 23 from the street site.

Key findings

Seventy-eight per cent of young people had used cannabis in their lifetime. Of the 58 who had used in the last 12 months, 35 (60%) were using daily. In response to the question 'How does cannabis fit into your life?', among the most popular responses were that using cannabis 'is relaxing' (22%), 'helps with boredom' (18%), 'helps me sleep' (15.5%), 'helps me forget problems' (11%), and makes me 'feel less nervous and stressed' (10%). The authors suggest that cannabis has become increasingly culturally tolerated and accepted in their community as a way of coping with problems. This can result in a more minimised view of cannabis and its negative impacts on the user and those around them. They argue that similar cultural accommodation has existed in their community and other similarly marginalised ones for benzodiazepines and other prescribed medications.

Based on their research and an examination of the literature on cannabis use, the authors identify 'significant concerns' (p. 26) with the impact of cannabis use on young people's engagement with education and the long-term impact on their memory and brain function. Daily cannabis users in the study were found to be experiencing problems with health, finances, family relationships, and educational/vocational performance. Some described an 'inability to regulate and control their use' (p. 27) and this was associated with a lack of engagement in structures such as educational or vocational training.

Fifty-seven per cent of the current users had considered changing their cannabis use in the past three months. In response to an open-ended question about what their reasons would be for reducing their use, financial implications emerged as the most important factor (20%). Others were employment (17.5%), physical health (17.5%), family relations (15%), and appearance, children, and mental health (all at 5%).

Cutting across the study was the finding that when compared to the street group, the young people who were in education or training and used cannabis used it less frequently; used a smaller amount when used; spent less on it; and were more motivated to change their use.

Recommendations

The final chapter of the report makes a number of recommendations for interventions and responses to the use of cannabis among young people.

Current knowledge base: There is a lack of knowledge about the current strains of herbal cannabis among some members of the community, service providers, and other stakeholders. The authors suggest that the 'high level of apathy' (p. 30) towards cannabis is often based on people's experiences of former strains of the drug that were of a lower potency. They recommend that stakeholders ensure that their institutional knowledge on problematic cannabis use is in line with current evidence. Also, that priority should be given to raising awareness among users, family members, and concerned others about the new strains of cannabis.

Prevention and early intervention: There needs to be ongoing support for prevention and early intervention responses to cannabis use. The authors suggest challenging the norms and attitudes to cannabis use, and increasing local and service user knowledge about cannabis and the impact of its use.

Targeted responses to daily users: Given the findings that a significant proportion of daily users of cannabis expressed an interest in changing their behaviour, the authors highlight the need to have tailored services to meet their needs. It is suggested that services draw on the international evidence base for this purpose.

Maintaining the focus of cannabis on community conversations and responses: The authors reflect on the 'heightened interest' (p. 31) that cannabis use has attracted as a result of the increasing prevalence of its problematic use, and its negative impact on users and communities, including problems related to drug-related debt and intimidation. They note that the momentum gathered through this and the consultation process for the new national drugs strategy should be maintained. Cannabis-related responses should be considered at all levels of policy and on national strategic platforms.

Lucy Dillon

1 O'Brien K and Foley B (2017) *'It's only weed': rethinking our response to young people's cannabis use*. Dublin: Ballymun Youth Action Project. <http://www.drugsandalcohol.ie/27246/>

2 The Equal Youth Cannabis Initiative in Ballymun is made up of representatives from a number of service providers working in Ballymun with early school-leavers (aged 16–24 years). They work to a model of interagency cooperation to meet the needs of these young people.

New strategy for Finglas Addiction Support Team

On 20 October 2017, the Finglas Addiction Support Team (FAST) launched their new strategic plan for 2017–2020 entitled 'Delivering our ambition: recovery for a better life'.¹ FAST offers a range of services, including drop-in; addiction counselling; polydrug use service; aftercare; family support; and the Recovery Coach programme. Their vision is 'leading an innovative centre of excellence where people can recover and have fulfilled lives in their community'; and their mission: 'we will provide accessible quality services for those affected by drug and alcohol use and mental health issues'. These are supported by four values: dignity, integrity, empowerment, and quality.

The new strategy has three priority areas, each of which is underpinned by a set of objectives:

Sustainability

- Ensure that resources are in place to underpin current and future services.
- Ensure that best practice governance is maintained and monitored throughout the organisation.
- Ensure that FAST has a supportive culture, robust organisational structure, and suitable competencies.

Innovation and growth

- Apply appropriate growth strategies to existing service level agreement objectives.
- Develop recovery-focused integrated care pathways to better meet the needs of participants with dual diagnosis.
- Continue to increase knowledge of evidence-based practice in addressing drug and alcohol use and mental health.
- Maintain a keen focus on the health and wellbeing of our participants, staff and wider community.

Collaboration and communication

- Influence attitudes and behaviours locally to reduce stigmatisation and marginalisation of people with addiction and mental health problems.
- Promote and raise awareness about the work of FAST within the community.

Lucy Dillon

¹ More information is available on the organisation's website at <http://www.fastltd.ie>



Problematic drug use and the needs of new communities and BME groups

The report *Stimulating and supporting a Black and minority ethnic voice on drug issues*¹ was published in April 2017 by CityWide Drugs Crisis Campaign, the national network of community activities and organisations involved in responding to drug-related issues. The research aimed 'to explore possible structures and processes through which to engage with, hear the voice of, and empower Black and minority ethnic communities in relation to issues of drug use' (p. 5). It was carried out by Niall Crowley, an independent public policy researcher with particular expertise in human rights and equality.

The findings of the report are based on 14 interviews with those working in community-based drug service provision (n=9), and representatives of Black and minority ethnic (BME) organisations (n=5). The author also reviewed two pieces of earlier research that explored the issue of drug use among new communities in Ireland.^{2,3}

Addressing the varying needs of new migrant communities as well as those of BME groups more generally is complex. The report focuses on the needs of new communities and their experience of cultural difference, in particular how this may impact on their experiences of accessing services and influencing policy in the area of drug use. Chapter 4 of the report focuses on 'difference', which is explored under the headings of situation, experience, and identity. The author emphasises that:

[It] underpins the need for a specific focus on these communities in policy and a specific place at the table in deliberating on policy. Difference points to specific risk factors, patterns of drug use, service needs, and communication channels that must be accommodated in policy and provision. (p. 15)

A hidden problem

There was general consensus among those interviewed that problematic drug use is an issue among BME groups, including new communities. However, its extent is unknown and its usage perceived to be largely hidden. While the National Drug Treatment Reporting System (NDTRS) of the Health Research Board has used an ethnic identifier for BME groups since 2008, the report suggests that a lack of presentation to appropriate services means that this is not yet a reliable indicator of the true extent of the problem. The report calls for more research so that this assessment can be substantiated.

Barriers to accessing services

Barriers to accessing services for new communities and BME groups are identified, including:

- A lack of targeted and culturally appropriate services
- A lack of knowledge of services among potential service users
- Language difficulties and, where a translator is used, concerns about confidentiality
- Community shame – the shaming of a person or group within their own community, as well as the risk that a person or group would shame that whole community
- Perceived and experienced racism, discriminatory behaviour and stereotyping among service providers
- Concerns about a person's legal or immigration status, where this is precarious. This includes concerns that a person would be deported or experience other repercussions if they approach services. This was particularly problematic for asylum seekers and undocumented migrants.

Second generation

A recurring theme throughout the report was the particular set of challenges faced by second-generation migrants that put them at increased risk of problematic drug use – an issue that has been recognised internationally. The reasons for this included 'their specific circumstances in the integration process' (p. 12) and their having 'specific stresses in grappling with new and old identities' (p. 13). Furthermore, dealing with racism and seeking peer acceptance within a culture that is different from that of their parents presents challenges. The hierarchical structures that exist within these communities and that influence and protect the young people can break down over time, providing an environment in which drug use may become a problem. There are also particular challenges to delivering prevention within this context. For example, parents feeling ill-equipped to discuss drugs with their children.

Informing policy-makers

The report identifies a number of ways in which policy-makers could be better informed about the issues facing new communities and other BME groups. These include:

- To document the stories of people from these groups who are involved in problematic drug use. These could be used to identify the range of issues faced in accessing services.
- To encourage the wider use of an ethnic identifier by service users, which would make BME people more visible to policy-makers
- To provide training for cultural competence among policy-makers
- To support research on the topic of drug use among BME groups
- To support processes of 'mutual education' between drug service providers and organisations working with BME communities
- To encourage community-based service providers to report on the diversity of their service users within policy fora
- To improve representation of key stakeholders from within BME groups in policy deliberations
- To encourage the inclusion of BME organisations with the Task Forces

Needs of new communities continued

New communities and national drug policy

One of CityWide's aims in commissioning this report was 'to enable Black and minority ethnic communities to influence the development and implementation of the National Drugs Strategy' (p. 5). The author notes that by the end of the timeframe of the previous drug strategy (2009–2016), there was 'little evidence reported of action in relation to new communities on foot of these commitments' (p. 7), i.e. commitments both to address the treatment and rehabilitation needs of new communities; and to develop engagement with new communities as a group identified as 'at risk' in relation to drug use. In the report, Crowley concludes:

Policy and provision in relation to problematic drug use have yet to respond appropriately and adequately to the needs of Black and minority ethnic communities. Institutional structures to underpin this policy and provision have yet to adequately engage the voice of these communities. This has happened in a context where, after a promising start, policy and provision on integration of new communities over the past decade has been limited. (p. 27)

The new national drugs strategy (2017–2025) was launched in July 2017.⁴ The needs of migrant communities were raised in the public consultation for the new strategy's development. It is recognised in the strategy that migrant communities 'may also experience barriers to accessing services or maintaining treatment, for a variety of reasons' (p. 47).⁴ One of the actions from the strategy's action plan (2017–2020) sets out to improve the capacity of services to accommodate the needs of people who use drugs and alcohol from specific communities (including new communities). This can be achieved by:

- Fostering engagement with representatives of these communities, and/or services working with them, as appropriate.

- Considering the need for specialist referral pathways for specific groups who may not otherwise attend traditional addiction services (i.e. those who engage in chemsex).
- Providing antiracism, cultural competency, and equality training to service providers.
- Ensuring all services engage in ethnic equality monitoring by reporting on the nationality, ethnicity and cultural background of service users for the NDTRS and treat related disclosures with sensitivity.

The Health Service Executive is identified as the lead agency in this work, with the community and voluntary sector as partners. The scope of these actions is similar to those of the previous strategy; and there continues to be no reference to participation by organisations representing new communities in the policy structures of the new strategy.

Following on from the report, CityWide held a round-table event with representatives from community drug service providers, BME organisations, and task forces. The aims of the session were to build cultural competence and knowledge among service providers about the situation, experience and identity of these communities, as well as to develop capacity and commitment among BME organisations to take up issues of problematic drug use in their policy work.⁵

Lucy Dillon

- 1 Crowley N (2017) *Stimulating and supporting a Black and minority ethnic voice on drugs issues*. Dublin: CityWide Drugs Crisis Campaign. <http://www.drugsandalcohol.ie/27501/>
- 2 Corr C (2004) *Drug use among new communities in Ireland: an exploratory study*. Dublin: National Advisory Committee on Drugs / Merchants Quay Ireland. <http://www.drugsandalcohol.ie/5897/>
- 3 Kelly C, Fitzpatrick C and Nic Gabhainn S (2009) *Substance use in new communities: a way forward*. Galway: Western Region Drugs Task Force. <http://www.drugsandalcohol.ie/11508/>
- 4 Department of Health (2017) *Reducing harm, supporting recovery: a health-led response to drug and alcohol use in Ireland 2017–2025*. Dublin: Department of Health. <http://www.drugsandalcohol.ie/27603/>
- 5 Personal communication with CityWide.

Community service: an alternative to imprisonment in Ireland

In October 2017, the Irish Penal Reform Trust (IPRT) in association with the Irish Criminal Bar Association held a seminar and launched a PhD research project 'Examining the comparative use, experience, and outcomes of community service orders as alternatives to short prison sentences in Ireland' by Dr Kate O'Hara.¹

Background

Community service orders (CSOs) first emerged in Ireland following the enactment of the Criminal Justice (Community Service) Act 1983 in December 1984.² According to this legislation, a CSO could only be enforced after imprisonment had been considered. With the aim of overcoming issues of underutilisation, reducing short-term prison (STP) stays, and helping offenders and the wider society, the Act was amended in 2011 to allow and encourage courts to impose a CSO as an alternative to short-term sentences (<12 months) as long as certain criteria were met.³

Aims and objectives

The main objective of the O'Hara study was twofold: first, to examine how CSOs were utilised and, second, to compare views, experiences and recidivism rates between two groups: those that received CSOs (n=6784) and those that received STP sentences (n=5231).

Community service continued

Methodology

The study used a mixed methodology approach. Data related to STPs (n=6784) and CSOs (n=5231) for the years 2011 and 2012 were provided by the Irish Prison Service and the Probation Service. This was subsequently linked to criminal history and rearrest data from An Garda Síochána. The analysis involved a comparative analysis (quantitative) and interviews (qualitative, n=21). Lastly, the frequency of rearrests was examined 12 and 24 months after leaving prison or beginning the CSO.

Results

The results indicated that, although offenders in the STP group were older than those in the CSO group, the number of previous convictions for the STP and CSO groups was similar. The likelihood of obtaining a CSO was influenced by province, court location, and court type. More CSOs were issued in Ulster, while fewer were issued in Munster and Connacht. No association was shown between CSOs and Leinster. The analysis of courts by location indicated that more CSOs were issued from rural courts. Moreover, a higher number of offenders received a CSO when a court was located far from a prison. These results should be interpreted with caution however as many of the effect sizes were small. Sanctions for drug offences resulted in a higher number of CSOs than STP sentences. Although this outcome was significant, the effect size was low. The average CSO length for drug offences was 164 hours (SD=56.1), while the average alternative prison sentence was 6.7 months.

For individuals whose original offences were drug offences:

- At six months, rearrests were higher in the CSO group when compared to the STP group, 21% (n=121) and 17% (n=68), respectively.
- At one year, rearrests were higher in the CSO group when compared to the STP group, 33% (n=194) and 30% (n=120), respectively.
- At two years (2011 only), rearrests were lower in the CSO group when compared to the STP group, 50% (n=151) and 54% (n=116), respectively.

Only a small proportion of offenders whose original conviction was for drug offences were reconvicted for drug offences; 21% (n=25) received CSOs and 13% (n=18) received STPs. Subsequent convictions included violent offences, property offences, road traffic offences, public order offences and other offences. Information on other offence categories can be viewed in the thesis.¹

Conclusion

O'Hara concluded that this was the first study of its kind to be carried out in an Irish jurisdiction. In order to implement and consider CSOs and other alternatives to imprisonment as acceptable, more research was needed along with changes to policy and practice.

Judge David Riordan, the Probation Service, Professor Mary Rogan, Mr David Perry BL, and the IPRT welcomed the findings of the study and acknowledged that it increased the knowledge and understanding of CSOs in Ireland. The Probation Service provided an outline of changes made thus far and examples of work carried out by offenders that have received CSOs to date and their plans for the future.

To coincide with the seminar, the IPRT published a discussion paper where they explore how the application of CSOs within the Irish criminal justice system can be improved.⁴ They identify a number of areas that need to be addressed to achieve this, such as evidence-informed policy, legislative reform, monitoring and review, promoting consistency, raising awareness, tailored community sanctions, addressing substance misuse, and further research.

Professor Rogan drew attention to the fact that the data in this study came from a variety of sources and of the importance of researchers having access to accurate and good quality data. She believes that this will provide a sustainable model to enable further exploration of the impact and usefulness of policies that are being implemented within the Irish justice system, while also allowing for changes and improvements to be captured. Collaborative work between the academic sector and practice and policy-makers was identified as the best route to achieving this.

Ciara H Guiney

- 1 O'Hara K (2016) *Examining the comparative use, experience, and outcomes of community service orders as alternatives to short prison sentences in Ireland*. Dublin: Dublin Institute of Technology. <http://www.drugsandalcohol.ie/27991/>
- 2 Criminal Justice (Community Service) Act 1983 at <http://www.irishstatutebook.ie/eli/1983/act/23/enacted/en/print>
- 3 Criminal Justice (Community Service) (Amendment) Act 2011 at <http://www.irishstatutebook.ie/eli/2011/act/24/enacted/en/html>
- 4 Irish Penal Reform Trust (2017) *Community service in Ireland: a qualitative exploration of one alternative to short-term imprisonment*. Dublin: Irish Penal Reform Trust. <http://www.drugsandalcohol.ie/28310/>

An Garda Síochána Policing Plan 2017

An Garda Síochána Annual Policing Plan 2017 identifies the main policing concerns for 2017.¹ Consistent with previous plans, it has considered the views of the community; An Garda Síochána (AGS); external stakeholders, including the Minister for Justice and Equality as well as the Garda Síochána Strategy Statement July 2016–2018;² ministerial directives; resource capacity; Joint Policing Committees; crime data analysis; and research. However, for the first time, in contrast to previous policing plans, priorities and targets have been agreed in talks between AGS and the Policing Authority, who will monitor how AGS will meet those targets. A number of areas have been highlighted by AGS in 2017: national and international security; confronting crime; roads policing; community engagement and public safety; and organisational development and capacity improvement.

National and international security

Due to ongoing challenges arising from terrorism and how it is funded, counterterrorism tactics are being strengthened. Drawing on an interagency approach between AGS, community and partner groups, and other law enforcement agencies both nationally and internationally, the emphasis is on prevention, overcoming challenges, sharing Intel, and prosecution. A key component of major emergency preparation involves training and risk assessment.

Confronting crime

A key element of AGS strategies is to deter crime. Existing multiagency approaches north and south of the Irish border have been effective in the fight against cross-border crime. This has been further strengthened by the formation of the Drugs and Organised Crime Bureau, which aims to actively target individuals associated with organised crime.

Roads policing

Saving lives is important to AGS. One area that influences this outcome is road safety. Already via multiagency collaboration there has been a decrease in road deaths. However, this plan acknowledges that more needs to be done to ensure road safety in Ireland is similar to that in other leading European countries. In order to do this, AGS aims to implement relevant legislation; analyse collisions; carry out 'targeted intelligence-led operations'; and increase the use of automatic number plate recognition technology (p. 12). Moreover, the Garda Traffic Corps is to be renamed the Garda Roads Policing Unit; this change will also involve greater visibility and policing functionality on Irish roads.

Community engagement and public safety

One of the core strengths of AGS is its ability to engage with and be part of the community. This plan builds on this strength via collaborative work that stresses the importance of crime prevention initiatives. In order to overcome the debilitating effects of fear caused by criminality, the aim is that AGS will have a highly visible presence and will continue to develop strong relationships within communities to increase trust and confidence. These steps will be further enhanced by the use of evidence-based interventions.

Organisational development and capacity improvement

In 2016, the Modernisation and Renewal Programme 2016–2021, a five-year initiative that aims to update the culture and structure of AGS, was launched.³ The initiative outlines the mission, direction, plans and challenges for AGS from 2016 to 2021. The programme is expected to give rise to a service that is more modern, accountable, professional, and performance driven. As an organisation, AGS recognises that an essential ingredient necessary to achieve this outcome is the unrelenting perseverance and steadfastness from the Garda, civilian and reserve members it employs. They are committed to making the right tools, guidance and support, appropriate training and development available along with the right leadership so that employees can carry out their roles effectively. They believe that this will enable AGS to take its place among world-class policing and security services globally. It is expected that the 2017 Policing Plan will have a genuine impact on the communities that AGS serves.

Ciara H Guiney

1 An Garda Síochána (2017) *An Garda Síochána Annual Policing Plan 2017*. Dublin: An Garda Síochána. <http://www.drugsandalcohol.ie/27736/>

2 An Garda Síochána (2016) *An Garda Síochána statement strategy July 2016–2018*. Dublin: An Garda Síochána. <http://www.drugsandalcohol.ie/27305/>

3 An Garda Síochána (2015) *An Garda Síochána modernisation and renewal programme 2016–2021*. Dublin: An Garda Síochána. <http://www.drugsandalcohol.ie/27306/>

Crime prevention and reduction strategy: putting prevention first

In April 2017, An Garda Síochána (AGS) published a crime prevention and reduction strategy.¹ This is not a national strategy but a 'proactive garda strategy' (p. 3) that aims to address criminality in Irish society. It provides a structure that endeavours to target specific criminal activities at a local, regional, or national level.

Purpose and expected outcomes

The central premise behind the strategy is that it would act as a resource and provide guidance on appropriate procedures that prevent and reduce crime. It will take a 'whole organisational approach' (p. 9) within AGS but will also consider the wider role of AGS where it acts as a coordinator and collaborator with partner agencies and other agencies in Ireland to reduce crime. It is presumed that a number of outcomes will be realised. For example, it is expected that the capability within AGS to prevent crime will increase. It is anticipated that crime and reoffending will reduce. Moreover, heightened safety and security within neighbourhoods should lead to a drop in the fear of crime, and the risk of becoming a victim of crime.

Principles of good practice

The strategy is informed by best international practice and UN Guidelines for the Prevention of Crime. AGS initially evaluated existing strategies and drew on what was learned from them to identify the most appropriate approaches to be used in Ireland. Although the themes that emerged were in alignment with the TRUST² transformation programme – which is currently reforming and modernising the AGS³ – such as collaboration with agencies from local to international level, programme integration across agencies, drawing on research and scientific evidence, measureable results, suitable analysis and funding, it was concluded that no intervention in isolation could reduce crime. What was considered vital was a multifaceted, multiagency approach centred on problem-solving but also based on strong scientific evidence.

Effective crime prevention strategies

It is highlighted that the *Crime prevention and reduction strategy* document is a working document and hence would need continuous appraisal, analysis, re-evaluation, and revision when necessary. It is acknowledged that what succeeds in one setting may not be suitable for another. Therefore, having a strategy that is sufficiently robust to achieve its outcomes is crucial, but at the same time it is essential that it is amenable to change or fine-tuning when needed.

Priority crime issues

Property crime, such as burglary and theft, are widespread in Ireland. However, the extent of crime and later victimisation is not. Moreover, what may be common in one area may not occur at all in another area. Hence, specific crimes are to be addressed in local policing plans and targeted by crime coordination units in each Garda region. As new crimes emerge, for example cybercrime, appropriate strategies centred on best evidence-based practice will be circulated to relevant stakeholders.

Monitoring, review and governance

The strategy will be monitored and reviewed to make certain that it continues to be aligned with the principles of the five-year TRUST programme.³ The strategy is being supervised by Superintendent, Garda Crime Prevention National Centre of Excellence in consultation with Regional Risk Compliance and Continuous Improvement Superintendents (p. 8). Within 18 months of commencement, an evaluation will be carried out, where any improvements identified will be acted upon.

Implementation plan

The implementation plan outlined by AGS centres on four pillars: building capacity, community partnership and collaboration, customised approaches, and crime prevention messages. AGS has identified the key objectives, actions to be taken, who is responsible for each action, and the expected outcomes (more detail available in Section 9 of the strategy document).¹

Conclusion

Having a crime prevention strategy is undoubtedly the most apt approach to address criminality and ensure safety within the community. The research suggests that the most effective way to reduce crime is to avail of a wide range of interventions. Moreover, Gardaí cannot singlehandedly resolve criminality in Ireland; this can only be achieved by engaging all of Irish society, from state agencies right down to individuals living in the community. This Garda-driven strategy is welcomed and will take important steps in preventing and reducing crime in Ireland.

Ciarra H Guiney

1 An Garda Síochána (2017) *Crime prevention and reduction strategy: putting prevention first*. Dublin: An Garda Síochána. <http://www.drugsandalcohol.ie/27147/>

2 Taking care of our communities; Renewing our culture; Unified governance and leadership; Supporting our people; Technology-enabled.

3 An Garda Síochána (2015) *An Garda Síochána modernisation and renewal programme 2016–2021*. Dublin: An Garda Síochána. <http://www.drugsandalcohol.ie/27306/>

Forensic Science Ireland: annual report 2016

Forensic Science Ireland (FSI), originally known as the Forensic Science Laboratory, delivers a scientific service that supports the Irish criminal justice system by analysing samples that are gathered at crime scenes (e.g. DNA, chemistry, and drugs). Moreover, it presents expert evidence in court, provides training, and carries out research. In order to do this effectively, scientists and analysts within the FSI draw on best international standards. In May 2017, the FSI published their annual report, which provided an overview of work carried out in relation to drugs in the course of 2016.¹

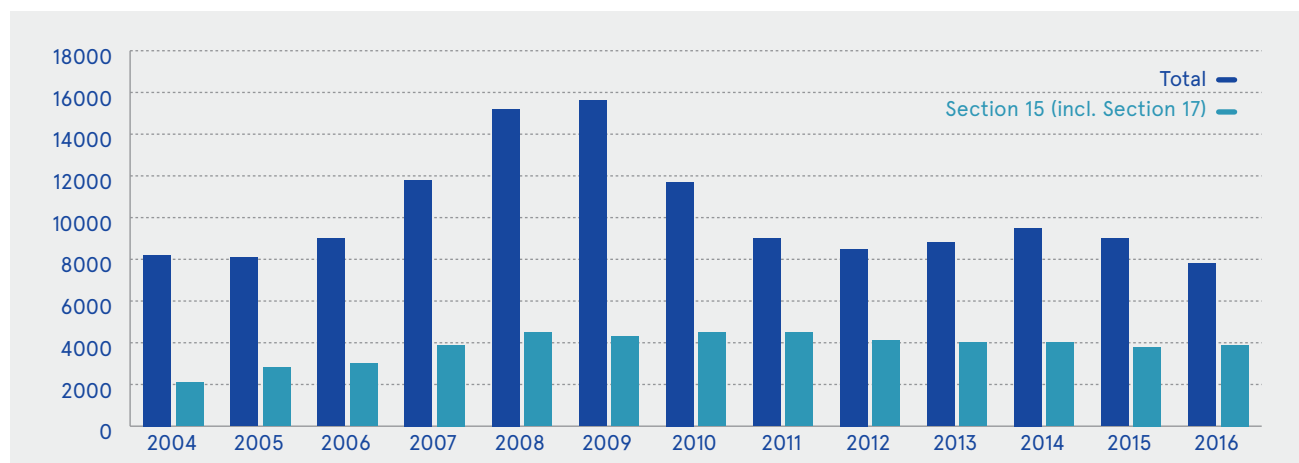
The majority of cases received by FSI centre on substances that violate the Misuse of Drugs Acts 1977–2015. Generally, substances are seized by An Garda Síochána; however, they

are also submitted by the Garda Síochána Ombudsman Commission (GSOC), Customs and Excise, and Military Police. A set procedure is in place to accept cases; following acceptance of substances by FSI reception or case intake staff, items are stored safely and securely and then passed to a relevant scientist for analysis. At all times the chain of custody is closely monitored.

Figure 1 provides a summary of drug trends between 2004 and 2016 for drugs that were submitted to FSI for analysis. Following a peak in overall drug submissions in 2009, submissions declined until 2012. Between 2012 and 2014 a slight increase was evident. Since 2014, a slight decreasing trajectory has been shown. A further analysis for drugs that contravene Sections 15 and 17 of the Misuse of Drugs Acts illustrated that between 2008 and 2016 the changes year on year have been very small.

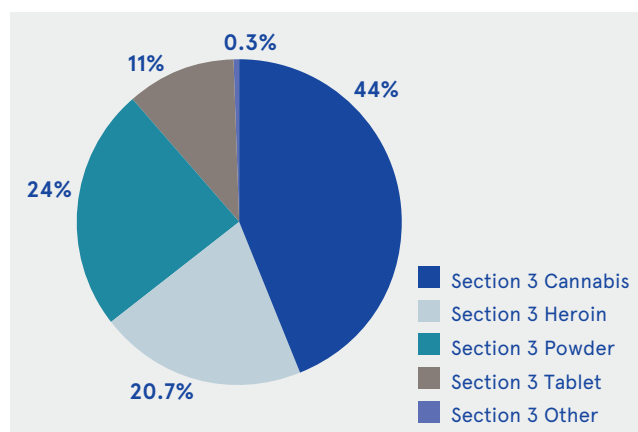
Figure 2 provides a summary of the number of cases analysed by drug type that contravened Section 3 of the Misuse of Drugs Acts in 2016. The majority of cases submitted were for cannabis (44%), followed by powder, and then heroin, 24% and 20.7%, respectively.

Figure 1: Trends in drug submissions to FSI from 2004 to 2016



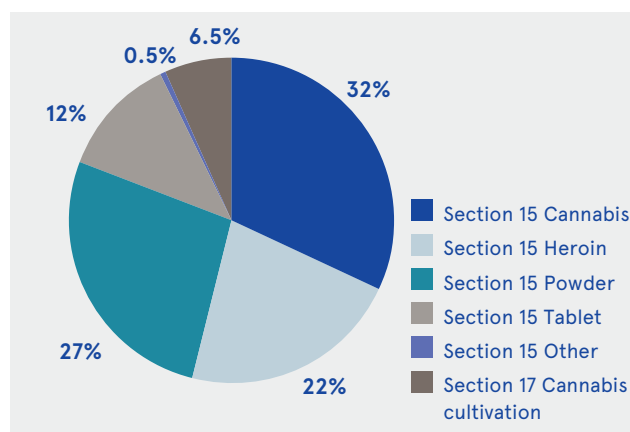
Source: Forensic Science Ireland annual report 2016, Figure 3, p. 13

Figure 2: Different types of Section 3 analysis carried out by the FSI Drugs Section. Section 3 offences involve possession of illegal drugs for personal use



Source: Forensic Science Ireland annual report 2016, Figure 4, p. 14

Figure 3: Different types of Section 15 analysis carried out by the FSI Drugs Section (Section 17 is also shown). Section 15 refers to possession of illegal drugs for sale or supply offences; Section 17 refers to cultivation or growth of illegal drugs



Source: Forensic Science Ireland annual report 2016, Figure 5, p. 14

FSI annual report continued

Similarly, under Section 15, the prevailing drug submitted was cannabis (32%), followed by powder and heroin, 27% and 22%, respectively, while under Section 17, cannabis cultivation accounted for 6.5% of the analysis performed (see Figure 3).

New substances

A number of new drugs were identified in Ireland in 2016, including:

- **Benzodiazepine drugs:** phenazepam, nitrazolam, etizolam, chlorodiazepam
- **Cathinone (stimulant) drugs:** pentylone, dipentylone, dibutylone, ethylhexedrone, N-ethylpentedrone, α -PVP, clephedrone, MPHP, PV8 (α -PHP), PV9 (α -POP), chloro-PVP, 4-chloro- α -PPP
- **Synthetic cannabinoids:** 5F-MDMB-PINACA, 5F-AKB-48, 5F-PB-22
- **Tryptamines (stimulant) drugs:** methyltryptamine, dimethyltryptamine, 5-MeO MiPT
- **NBOMes:** 25I-NBOMe
- **Fentanyl (opiate-type) drugs:** fentanyl, pentanoyl fentanyl, 2-fluorofentanyl
- **Other drugs:** 3-fluorophenmetrazine (stimulant-type drug)

The emergence of new substances creates a challenge for FSI, as no reference standards are available to which they can be compared. Moreover, individuals that use these new products are at higher risk, as toxicity levels are substantially higher than similar drugs. For example, the report refers

to a case that occurred at a house party attended by young people in Cork in 2016. Powder that was assumed to be a designer drug called 2CB was consumed and high levels taken as a result. FSI later identified the powder as 24I-NBOMe (N-Bomb), a toxic hallucinogenic drug. In this instance, the amount consumed was one hundred times higher than the normal dose and resulted in the death of one young male.

Court appearances

In 2016, requests for FSI to appear in court were low. Despite this, defence teams visited FSI on a number of occasions, many of which were connected to the reassessment of drug seizures (n=34).

Purity

Purity levels in cocaine were generally 40%. A number of other compounds were found, such as levamisole (used by vets), benzocaine and lignocaine (used by dentists) and phenacetin (used as an illegal painkiller). With regard to heroin, purity levels were about 33%, and other compounds present included combinations of phenacetin, paracetamol, and caffeine.

Out-of-hours service

An out-of-hours service consisting of one scientist and a small team (n=20) were at hand to attend crime scenes and carry out laboratory work when needed. Overall, urgent drug analysis was required seven times and crime scene visits occurred 14 times, one of which was to a clandestine drug laboratory.

Ciara H Guiney

1 Forensic Science Ireland (2017) *Forensic Science Ireland annual report 2016*. Dublin: Forensic Science Ireland.
<http://www.drugsandalcohol.ie/27308/>





National Drugs Library

UPDATES

Recent publications

The following abstracts are cited from published journal articles recently added to the repository of the HRB National Drugs Library at www.drugsandalcohol.ie

POLICY AND LEGISLATION

Ireland's Public Health Bill: crucial to reduce alcohol harm

Murray F (2017) *Lancet*, 390 (10109): 2222.
<http://www.drugsandalcohol.ie/28100/>

Ireland has become the fourth heaviest drinking nation in the Organisation for Economic Co-operation and Development in terms of quantity of alcohol consumed, and ranked joint third for binge drinking in an analysis of 194 nations by WHO. Irish adults consume on average 11.5 L of pure alcohol per person every year, an increase of more than 100% compared with 60 years ago. Most alcohol in Ireland is now consumed at home and alcohol retailing off licences have increased by five-fold since 1990. Despite high alcohol taxes and duties, cheap alcohol is sold in many more outlets.

PREVALENCE AND CURRENT SITUATION

A national survey of online gambling behaviours

Columb D and O'Gara C (2017) *Irish Journal of Psychological Medicine*. Early online.
<http://www.drugsandalcohol.ie/28197/>

The aim of this study is to look at an Irish population in relation to the online gambling activities people are engaging with, the reasons for gambling online, their attitudes to online gambling and the financial/mental health consequences of online gambling.

Online gamblers in Ireland share similar behavioural profiles to online gamblers in the United Kingdom and worldwide. The majority of participants in this research have been adversely affected from both a mental and financial perspective due to their gambling behaviours.

A high prevalence rate of a positive screen for cognitive impairment in patients with Human Immunodeficiency Virus attending an Irish clinic

McNamara PH, Coen R, Redmond, J, Doherty CP and Bergin C (2017) *Open Forum Infectious Diseases*, 4(1): ofw242.
<http://www.drugsandalcohol.ie/28177/>

Human immunodeficiency virus (HIV)-associated neurocognitive disorders occurs in 20%-50% of HIV-positive patients. We undertook this study to assess the prevalence of a positive screen for cognitive impairment in the clinic population at our institution and to demonstrate the feasibility of implementing a screening program in routine clinical encounters.

The study highlights the necessity for a structured, prospective, large-scale screening program for cognitive impairment across countries with limited resources and demonstrates the feasibility of easily implementing this with minimal training.

Treatment for opioid use and outcomes in older adults: a systematic literature review

Carew AM and Comiskey C (2018) *Drug and Alcohol Dependence*, 182: 48-57.
<http://www.drugsandalcohol.ie/28129/>

Historically, issues relating to problem substance use among older people have received little attention, and have only recently been recognised.

Findings suggest that little is known about treatment outcomes among older people. Problematic drug use (of which opioids make up the largest proportion) had been incorrectly assumed to end as patients age. Defining an age limit for 'older' is important. Addiction and healthcare services must anticipate and prepare for increased demand by this group.

Recent publications continued

Self-harm, methadone use and drug-related deaths amongst those registered as being of no fixed abode or homeless in Ireland

Glynn RW, Lynn Ena, Griffin E, Fitzgerald M and Ward M (2017) *Irish Medical Journal*, 110(9): 631.
<http://www.drugsandalcohol.ie/27977/>

This work aims to contribute to the evidence base regarding the health of those who experience homelessness in Ireland by collating data on methadone use, drug-related deaths and emergency department presentations due to self-harm.

The number of drug-related deaths amongst those of NFA or homeless and who died in Dublin fluctuated from 2004–13 with an overall upward trend. There is an urgent need to adequately resource and coordinate those services which aim to address factors (social and health inequalities, mental ill-health and addiction) which lead people into – and prevent them exiting from – homelessness.

Concurrent use of alcohol interactive medications and alcohol in older adults: a systematic review of prevalence and associated adverse outcomes

HHolton AE, Gallagher P, Fahey T and Cousins G (2017) *BMC Geriatrics*, 17(1): 148.
<http://www.drugsandalcohol.ie/27636/>

The aim of this study was to systematically review the prevalence of concurrent use of alcohol and alcohol-interactive (AI) medicines in older adults and associated adverse outcomes.

While there appears to be a high propensity for alcohol-medication interactions in older adults, there is a lack of consensus regarding what constitutes an AI medication. An explicit list of AI medications needs to be derived and validated prospectively to quantify the magnitude of risk posed by the concurrent use of alcohol for adverse outcomes in older adults. This will allow for risk stratification of older adults at the point of prescribing, and prioritise alcohol screening and brief alcohol interventions in high-risk groups.

A multi-country study of harms to children because of others' drinking

Laslett AM, Rankin G, Waleewong O, Callinan S, Hoang HTM, Florenzano R, *et al.* (2017) *Journal of Studies on Alcohol and Drugs*, 78(2): 195–202.
<http://www.drugsandalcohol.ie/27620/>

This study aims to ascertain and compare the prevalence and correlates of alcohol-related harms to children cross-nationally.

Family-level drinking patterns were consistently identified as correlates of harm to children because of others' drinking, whereas sociodemographic factors showed few obvious correlations.

Home manufacture of drugs: an online investigation and a toxicological reality check of online discussions on drug chemistry

Hearne E, Alves EA, Van Hout MC and Grund JPC (2017) *Journal of Psychoactive Drugs*, 49(4): 279–88.
<http://www.drugsandalcohol.ie/27580/>

We illustrate here how online communal folk pharmacology of homemade drugs on drug website forums may actually inform home manufacture practices or contribute to the reduction of harms associated with this practice.

Drug discussion forums should consider re-evaluating their policies on chemistry discussions in aiming to reach people who cannot or will not refrain from cooking their own drugs with credible information that may contribute to reductions in the harms associated with this practice.

Characteristics of methadone-related overdose deaths and comparisons between those dying on and off opioid agonist treatment (OAT): a national cohort study

Van Hout MC, Crowley D, Collins C, Barry A, Lyons S and Delargy I (2017) *Heroin Addiction and Related Clinical Problems*. Early online.
<http://www.drugsandalcohol.ie/27568/>

We describe characteristics of methadone related overdose deaths and assess if differences exist between those dying on and off opioid agonist treatment (OAT).

Methadone related fatal overdose is a significant cause of death in young Irish, who share many characteristics with other drug related deaths. Improved monitoring, risk assessment and OAT retention strategies is warranted to inform national drug overdose plans and overdose prevention.

A cross-national study on gender differences in suicide intent

Freeman A, Mergl R, Kohls E, Székely A, Gusmao R, Arensman E, *et al.* (2017) *BMC Psychiatry*, 17(1): 234.
<http://www.drugsandalcohol.ie/27550/>

The aim of this study is to explore gender differences in suicide intent in a cross-national study of suicide attempts. The secondary aims are to investigate the gender differences in suicide attempt across age and country.

Considering the differences in suicidal intent between males and females highlighted by the current study, gender targeted prevention and intervention strategies would be recommended.

Recent publications continued

Anxiety and depression among patients with alcohol dependence: co-morbid or substance-related problems?

Gallagher C, Radmall Z, O’Gara C and Burke T (2017) *Irish Journal of Psychological Medicine*. Early online. <http://www.drugsandalcohol.ie/27544>

The aim of this study was to characterise rates of co-morbid psychiatric symptoms among a group of individuals commencing treatment for alcohol dependence, and to examine the stability of these symptoms following treatment of the alcohol problem.

The significant change in rates of reported symptoms following completion of treatment suggests that a large proportion of symptoms reported at treatment entry were substance related. Diagnosing co-morbid conditions is best left until after a period of abstinence during which the alcohol problem has been treated. Assessing for co-morbidity at time of treatment seeking is likely to result in inappropriate co-morbid diagnoses being made and inappropriate or unnecessary treatments being prescribed for such individuals.

Drinking context and cause of injury: emergency department studies from 22 countries

Korcha RA, Cherpitel CJ, Bond J, Ye Y, Monteiro MG and Chou P (2017) *Journal of Substance Use*. Early online. <http://www.drugsandalcohol.ie/28096/>

It is estimated that up to a third of injuries requiring emergency department (ED) admission are alcohol-related. While injuries that are alcohol-related are unsurprising to ED staff, less is understood about the precursors to the injury event.

Understanding the cause and context of injury and alcohol use are important components to evaluation and development of alcohol policies.

RESPONSES

Working with clients with addiction: what psychologists need to know

O’Driscoll C and Foy S (2017) *The Irish Psychologist*, 43(12): 16–20. <http://www.drugsandalcohol.ie/27973/>

Addiction is a common problem that practitioner psychologists face with their clients. It is however, the view and experience of the authors that specialised training in addiction treatment for psychologists is sparse, inconsistent and incomprehensive.

This article aims to give some context to the nature of these issues and the challenges facing practitioners, offer an overview of evidence in the treatment of addiction, and finally conclude with some guidance to psychologists in the treatment of these issues in the psychotherapeutic context.

How do individuals develop alcohol use disorder after bariatric surgery? A grounded theory exploration

Yoder R, MacNeela P, Conway R and Heary C (2017) *Obesity Surgery*. Early online. <http://www.drugsandalcohol.ie/28007/>

The aim is to construct a theory to explain the development of AUD (alcohol use disorder) among a sample of individuals who reported problematic drinking following RYGB (Roux-en-Y gastric bypass).

The theoretical framework of ‘filling the void’ adds to contemporary research that conceptualises AUD behavioural substitution as ‘addiction transfer’ by describing the process by which the phenomenon occurs as well as the characteristics of participants. The clinical implication of this research is to advocate for a reshaping of treatment of RYGB patients, with increased psychological input following surgery.

Experiences of men with psychosis participating in a community-based football programme

Moloney L and Rohde D (2017) *Irish Journal of Occupational Therapy*, 45(2): 100–111. <http://www.drugsandalcohol.ie/27981/>

This study highlights the value and meaning of participation in football for men with psychosis, as well as demonstrating the longer-term feasibility of football as a therapeutic medium in Occupational Therapy mental health service provision. Findings could help to promote the routine use of sports interventions to mental health services.

Risk of repeated self-harm and associated factors in children, adolescents and young adults

Bennardi M, McMahon E, Corcoran P, Griffin E and Arensman E (2016) *BMC Psychiatry*, 16(1): 421. <http://www.drugsandalcohol.ie/27940/>

Repeated self-harm represents the single strongest risk factor for suicide. To date no study with full national coverage has examined the pattern of hospital repeated presentations due to self-harm among young people.

Young people with the highest risk for repeated self-harm were 15–19-year-old females and 20–24-year-old males. Self-cutting was the method associated with the highest risk of self-harm repetition. Time between first self-harm presentations represents an indicator of subsequent repetition. To prevent risk of repeated self-harm in young people, all individuals presenting at emergency departments due to self-harm should be provided with a risk assessment including psychosocial characteristics, history of self-harm and time between first presentations.

Recent publications continued

Implementing a tobacco-free hospital campus in Ireland: lessons learned

McArdle D and Kabir Z (2017) *Irish Journal of Medical Science*. Early online.
<http://www.drugsandalcohol.ie/27706/>

The aims of this study are to examine hospital staff awareness and to assess the progress of selected HSE health care facilities towards a TFC (tobacco-free campus) policy.

Staff awareness of the HSE TFC policy across selected health care facilities in Ireland is positive but is not sufficient. There are gaps in the implementation process of the HSE TFC policy in the health care facilities. Therefore, proper communication on the importance of the ENSH-Global standards and cessation training to all staff is necessary to help reduce smoking rates across the health care facilities and also to move towards a Tobacco Free Campus in Ireland.

Exploring patient characteristics and barriers to hepatitis C treatment in patients on opioid substitution treatment attending a community based fibro-scanning clinic

Crowley D, Cullen W, Laird E, Lambert JS, McHugh T, Murphy C and Van Hout MC (2017) *Journal of Translational Internal Medicine*, 5(2): 112–119.
<http://www.drugsandalcohol.ie/27666/>

Hepatitis C virus (HCV) infection is a major public health issue. There is substandard uptake in HCV assessment and treatment among people who inject drugs (PWID). Community fibroscanning is used to assess disease severity and target treatment.

The study highlights the usefulness of community fibroscanning. Identifying barriers to treatment in this cohort affords an opportunity to increase the treatment uptake. The availability of afternoon clinics and enhanced prison linkage are warranted.

Core addiction medicine competencies for doctors, an international consultation on training

Ayu AP, El-Guebaly N, Schellekens A, De Jong C, Welle-Strand G and Small W (2017) *Substance Abuse*, 38(4): 483–87.
<http://www.drugsandalcohol.ie/27667/>

We undertook this study to assess the views of international scholars, representing different countries, on the core set of addiction medicine competencies that need to be covered in medical education.

While it is unclear whether a global curriculum is needed, a consensus on a core set of principles for progression of knowledge, attitude and skills in addiction medicine to be developed at each educational level amongst medical graduates would likely have substantial value.

Community pharmacist experiences of providing needle and syringe programmes in Ireland

McVeigh J, Hearne E, Bates G and Van Hout MC (2017) *Research in Social Administration and Pharmacy*, 13(4): 767–77.
<http://www.drugsandalcohol.ie/27519/>

The aim was to understand and illustrate pharmacist experiences of providing NSP (needle and syringe programmes).

Further enhancement of NSP coverage and targeted service delivery within national care pathways for drug and alcohol services is warranted.